LOUISIANA YOUTH ENHANCED SERVICES

LA-Y.E.S.

CRISIS IN CHILDREN'S MENTAL HEALTH:

LA-YES CHILDREN'S MENTAL HEALTH PLAN

2007/2008

CHERYLL BOWERS STEPHENS, MD, MBA
PRINCIPLE INVESTIGATOR AND INTERIM PROJECT DIRECTOR

LA-Y.E.S.
210 STATE STREET
COTTAGE #4
NEW ORLEANS, LA 70018
PHONE 896-2636

TABLE OF CONTENTS

LA-Y.E.S.

CRISIS IN CHILDREN'S MENTAL HEALTH: A CHILDREN'S MENTAL HEALTH PLAN 2007/2008

PART I

LOUISIANA YOUTH ENHANCED SERVICES (LA-Y.E.S.)

LA-Y.E.S. is a system of care established for children and youth with serious emotional and behavioral disorders funded through a cooperative agreement between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Louisiana Office of Mental Health. LA-Y.E.S. serves a five parish area (Orleans, Jefferson, Plaquemines, St. Bernard, and St. Tammany). It has re-established services in Orleans, Jefferson, Plaquemines Parishes, and is staged to initiate services in St. Bernard and St. Tammany Parishes in the next year.

The history of the development of mental health services for children has lead to the growing number of systems of care nationally which now encompass every state and includes many sub-areas (Pires, 2002). LA-Y.E.S. is a system of care which builds upon prior federal initiatives partnering with state and local public mental health programs for improving mental health services for children and youth. In 1983, the Child and Adolescent Services Program (CASSP) was initiated focusing on services which address the mental health needs of all children. In the 1980's, family voices emerged with the growth and development of federations of families and alliances of the mentally ill. Foundations funded managed care initiatives setting up models of care emphasizing systems of care development. In 1992, Congress funded "comprehensive community mental health services for children and their families" which by now has extended systems of care in all states. Foundations also funded initiatives which demonstrated the importance of family supports in care and in promoting youth development. LA-Y.E.S. is a Louisiana cooperative agreement between the Center for Children's Mental Health Services of SAMHSA and local partners where the values and principles of systems of care are implemented.

LA-Y.E.S. has committed to developing a system of care for children and youth by implementing the values and principles of the systems of care as first articulated by Stroul and Friedman (1986):

- Values
    - Services are child centered and family focused, community-based, and culturally and linguistically competent.
- Principles
    - Access to comprehensive services; individualized services; least restrictive environments; family participants in all aspects of service planning; service systems integrated; all children have care management; children's problems are

identified early; youth emerging to adulthood transitioned into adult care; the rights of service recipients are protected; and services are non-discriminatory.

LA-Y.E.S. has joined with community partners to work with families and youth addressing children's mental health. Critical collaboration partners include mental health, juvenile justice, child welfare, education, health, and human services (social services) areas. Service integration may start in family courts or in schools, or from a wide variety of other community portals. Services are characterized by coordination, multi-disciplinary teams, comprehensive array of services, community-based, culturally and linguistically competent, evidence-based, and outcome oriented. This "wraparound" approach itself is an evidence-based model based on national evaluations funded to evaluate all federally funded systems of care.

The mental health system in the United States is in disarray according to the President's New Freedom Commission on Mental Health released in 2003. Therefore, the transformation of the system has been in the focus of policymakers for the past three years. Three main obstacles Americans with mental illness getting the care they need:

- The stigma associated with mental illness;
- The unfair treatment limitations and financial requirements placed on receiving care; and
- The fragmented mental health service delivery system.

Mental health care in the region served by LA-Y.E.S. is not only characterized by these obstacles, but coping with the aftermath from the largest disaster in our national history has left those with mental illness with even greater burdens of stigma, with a near collapsed public mental health care delivery system, with a region without the resources to reconstruct an adequate service delivery system, and with families facing a service delivery system that is not only fragmented but virtually non-existent. This will be illustrated in the sections that follow.

The Chinese word for "crisis" combines two characters, one of which is for "risk", and the other is for "opportunity". We believe that though the ravages of the aftermath of Hurricane Katrina has left us vulnerable, and the devastation following the breakdown of the levee system has left us without basic infrastructural supports, that we now have opportunities to re-establish a system of care for those children and their families in our region that reflects a "transformed" system of care. Building upon recommendations from the President's New Freedom Commission, and integrating principles supporting "transforming mental health care" (SAMHSA, 2005), we envision a system of care that is more comprehensive than existed prior to the disaster. SAMSHA articulated a vision where mental health is essential to overall health, care is consumer and family driven, where disparities in services are eliminated, where early interventions are the norm, where care is evidence-based, and where technology maximizes benefits.

Our vision is to rise above the ruins that hold captive some of our neighborhoods, to put together a responsive community-based care delivery system, and to advocate for the resources necessary to end the suffering of children and their families brought on by systems challenges. While the local media decry the collapse of the mental heath care delivery system, we put forth a plan for children that cries out for a united stakeholder call for action. This vision is based on the best thinking on improving care, on the available evidence for what works, and for the respect families deserve.

Reforms of our systems are supported by our federal partners through the development of a system of care in our region. This plan articulates immediate steps and long range views on the way to fulfilling this vision. It is shaped by the support we employ to this effort from wide corners of our communities, from a wide array of child-serving agencies and practitioners, and

from a public that is suffering from a lack of basic mental health care in our communities. The American Academy of Child and Adolescent Psychiatry (2007) has called for action to implement plans which reflect the values and principles of community systems of care. This children's mental health plan addresses these principles and practices.

Since its inception of services in 2005 in the area, LA-Y.E.S. has served over 155 children and their families in its service network. Services collapsed immediately following the widespread disaster from flooding and also from the hurricane. All of our children and families were displaced by the flooding and by the storm. Post-Katrina, we have re-established services and currently serve more than 65 families. Through its evaluation of services funded by the cooperative agreement, children demonstrate improved emotional and behavioral well-being, improved functioning, and families report improved family life and high levels of service satisfaction.

LA-Y.E.S. began its work of planning for services in the service area in 2004 and began seeing families and youth in 2005 focusing in Orleans Parish. The devastating disaster in 2005 forced a restart of services in 2006 with a focus on Jefferson, Orleans, and St. Plaquemines Parishes. Within the next year, services will be expanded to St. Bernard and St. Tammany Parishes.

This service plan guiding LA-Y.E.S. in the next year examines demographic and epidemiological data in the service delivery area. Vulnerable populations are noted in this community-based care delivery collaborative effort. Community partners and families were involved in processes of gathering their ideas about the future directions of the systems of care development. Post-Katrina, a variety of professional, foundation-supported, and local initiatives have helped articulate the needs of children influencing the mental health of children in our area so deeply impacted by the hurricane and the flooding. This plan reflects a wide variety of input into our plan for addressing children's mental health and our recommendations for future directions.

CHILDREN/YOUTH AND THEIR FAMILIES IN THE LA-Y.E.S. SERVICE AREA

Demographic Characteristics and Epidemiological Data

The population in the five parish service area has experienced dramatic shifts Post-Katrina. The chart below indicates dramatic declines in the population and in the numbers of children in Orleans and St. Bernard Parishes, and an increase in the population of St. Tammany Parish. Survey data of families in the area Post-Katrina indicate an extensive impact on dislocations (even of those in the area), and various features which make many vulnerable to challenges to rebuilding their lives.

Population Characteristics: US Census Data Occasional Report (January 17, 2007)

	Orleans	Jefferson	St. Bernard	Plaquemines	St. Tammany
Population	191,139 (-54%)*	434,666 (-5%)	25,296 (-77%)	17,860 (-16%)	220,656 (+21%)
# children (0-24)	56,469	138,885	7,380	6,165	76,421
# children enrolled in public schools	25,651**	43,617	3,536	4,374	35,294
% change in residence due to hurricane damage	34.9%	25.6%	86.5%	34.6%	22.2%
% adults employed	47.1%	43.3%	49.4%	38.5%	51.0%
Uninsured	20.4	17.7%	22.6%	16.5%	13.8%
Reported serious mental health condition	16.3%	8.3%	18.6%	10.5%	9.9%
% children (4-17) at poverty level	6.4%	4.8%	1%	7.1%	2.25

*Census data percent of increase/decrease reported by Times Picayune (March 13, 2007)
**reported by the Greater New Orleans Community Data Center, for October 2006.

The Times Picayune population estimate for Metropolitan area (March 11, 2007) describes the decline in population in the service area (Pre-Katrina: 1,292,774/ Post-Katrina at 800,715 indicating a 22% decline).

The populations of the service delivery areas have shown changes Post-Katrina though reflecting wide diversity and maintaining its rich traditions of cultural diversity. Further information on the population characteristics was provided by the Census Report (2007).

Parish level population percentages by race

	Orleans	Jefferson	St. Bernard	Plaquemines	St. Tammany
African Am	47.0%	25.9%	7.3%	18.0%	9.7%
Caucasian	42.7%	61.2%	87.6%	74.3%	85.4%
Asian/PI	4.6%	4.5%	1.1%	.8%	.6%
Latino	9.6%	9.7%	5.5%	5.4%	4.6%
Nat. Am	.4%	.1%	.6%	1.1%	0%
Other (multi)	5.2%	8.3%	3.4%	5.8%	4.3%

One aspect of the rich cultural history of the service area is a change in immigrant populations in the area. Though numbers are difficult to assess in examining the newer populations, some indications are that Post-Katrina changes have increased this population and many of these families and their children are at risk for emotional and behavioral health challenges.

- Immigrant data in the service area as reported by the American Immigration Law Forum (2006) and the Census Bureau Data (August 16, 2006) reports on changing characteristics:
    - LA foreign born population (121,590) 2.8% of population (4.5% growth since 2000 census).
    - Foreign born immigrants represent 9.3% of the states population (American Immigration Law Reform).
    - The Census Bureau reports 8.4% of states population are foreign born (US Census Bureau, 2007).
    - 19.4% of these arrived since 2000.
    - 6% growth in foreign born in Louisiana from 2000 to 2005 (Fussell, 2007). Surveys of contract workers in the Metropolitan area in 2006 indicate 50% are Latino and 30% foreign born.

Snapshots data indicate Post-Katrina challenges for reconstruction of communities are evident in a wide host of indicators. Some of these indicators tracked by the Greater New Orleans Community Data Center illustrate the disparate disaster impact on the communities. The following data is regularly reported and updates in what they call the Katrina Index (Greater New Orleans Community Data Center, March, 2007).

Snapshot Data

Residential properties for sale (February) in Orleans Parish	4,971
Number of demolitions (February, 2007)	2,971
Cumulative residential permits (Orleans)	53,994
Number of new housing permits (Orleans)	725
Road Home applications/closings (3.12.2007)	115,185 applications/ 2,921 closings
Bus routes/buses in Orleans Parish	47% routes operating; 17% of buses operating
Open public Schools (Orleans/St. Bernard)	44% Orleans; 20% St. Bernard
Percent of hospitals in operation (Orleans/Jefferson/St. Bernard)	52% Orleans; 93% Jefferson; 0% St. Bernard
Operational Child Care Centers (Orleans; Jefferson; Plaquemines; St. Bernard)	83% Jefferson; 71% Plaquemines; 32% Orleans; 8% St. Bernard
% Libraries open (Orleans; Jefferson; Plaquemines; St. Bernard; St. Tammany)	62% Orleans; 69% Jefferson; 33% Plaquemines; 0% St. Bernard; 92% St. Tammany

It is difficult to assess the mental disorder prevalence (epidemiological impact) in post disaster areas (partially natural and partially man-made) with the magnitude and scale unlike

none other this country has ever experienced. Estimates are based on a variety of methodologies such as tracking hospital admissions, from clinic reports, from epidemiological surveys, and from other estimations. Childhood disorders nationally are estimated by SAMHSA based on a wide variety of these data sources and were reviewed by Surgeon General Satcher. These general population estimates are provided below.

(SAMHSA, March 25, 2007).

Disorders	**"n" per /100 estimates**
Anxiety Disorders	13/100
Major Depressive Disorder	2/100
Bipolar Disorder	1/100
Attention Deficit/Hyperactivity Disorder	5/100
Learning Disorders	25/100
Eating Disorders (anorexia and bulimia)	4/100
Autism	12/100
Psychotic Disorders	.5/100
All Disorders Combined	16/100
(disorders among boys)	18/100
(disorders among girls)	14/100

Based on post-disaster epidemiologic estimates, we know that how children handle the stress post-disasters is based on how well their families cope with the impact. As the area moves through the recovery and reconstruction phases, many children experience symptoms related to Post Traumatic Stress Disorders (PTSD), though most may not meet all diagnostic criteria for PTSD but have related traumatic stress symptoms. Most symptoms relate to behavioral and emotional symptoms such as hyper-arousal, mood disturbances, anxiety symptoms, intrusive thoughts, and distress (Silverman and LeGreca, 2006). Lister (2005) summarized the mental health consequences of disasters in a report to congress.

An assumption reflected in this plan is that we have a somewhat increased rate of PTST but certainly all the children in our area are coping with increased measures of stress, with traumatic stress being widespread in our area. Some factors exacerbate coping with traumatic stress for children and youth, such as poverty, dislocation, change in communities, families coping with stress, and female and minority status. Thus, given the population characteristics in our area, we estimate most children are coping with increased levels of traumatic stress.

The National Child Trauma Network (2004) reports national data on child traumatization:

- Increasing access for youth to trauma informed services.
- Adolescent prevalence (2% direct assaults; 23% direct assault and witness; 48% witness).
- 1995 data (2,000 child abuse deaths; 565,000 injuries; 1,100,000 confirmed abuse/neglect cases).

Madrid and others (2006) summarize symptomology common to children and youth exposed to traumatic stress such as most youth in our service area. They summarize data from studies of terrorist attacks and natural disasters: children suffer from direct and indirect exposure; the more risk, the more symptoms; the more the family impact, the more childhood problems. Common manifestations include: increased regression; clinging; inattentiveness; aggression; bedwetting; somatic; irritability; social withdrawal; nightmares; and crying. More

sever impacts are less frequent: depression; anxiety; adjustment; PTSD; interpersonal problems; and academic problems. The most vulnerable children are: homeless; in foster care; exposed to violence; are poor; and have special health needs. Moderators include: age; developmental level (older youth and girls are more at risk); and intellectual capacity.

Children and youth who experience trauma may express emotional and behavioral problems as a result of the trauma. It is not likely that most children who have been traumatized will develop post traumatic stress disorders. Copeland and others (2007) note two key points to remember:

- First traumatic experiences are common but do not usually cause post traumatic stress disorders.
- The risk of post traumatic stress symptoms increases with subsequent exposure to traumatic events.

A concern community's monitor to address heightened stress levels is the potential risk of suicide for vulnerable populations. We are reminded of this in a recent mental health alert (Mental Health America Alert, February 5, 2007).

- Suicide rates nationally among youth increased in 2005 from a reported 7.3 per 100,000 to 8.2 (11% increase) for youth ages 10-19; for the younger of youth ages 10-14, it increased from 1.2 to 1.3/per 100,000 (8% increase).
- The 1999/2001 reported suicide rate in Louisiana for youth 12-17 was .04 per 100,000 and from 18-20 year olds it was 1.3 per 100,000. In our area, St. Tammany, St. Bernard, and Jefferson had slightly higher than state averages.

We do not have Post-Katrina data estimates on suicide rates.

The stress children and families in our area experienced were captured in a report of surveys of dislocated families and those rebuilding in our areas. Golden (2006) reports on the "Katrina Impact":

- 39,000 children impacted in NO; 116,307 in area (5 or younger).
- 270,000 people were in shelters post-storm; 20,000 from NO.
- Most in shelters experienced direct trauma.
- 33% of adults in shelters had reported that Katrina-caused health or mental health problems.
- 40% of those in shelters were separated from family due to the disaster.
- 22% of adults reported being separated from children.
- Most traumatized children experience mental health problems.
- Parent's coping dictates the impact on children.
- Many of children already have experiences with trauma; combined adding of traumatic experiences further fosters symptom expression and related suffering.
- Most of the youth impacted in need of help are not in services.

The National Center for Disaster Preparedness (2007) reported to have surveyed Mississippi families displaced by Katrina and summarized their findings: (those who are poor experience greater impact of disaster—lack of resources for managing finances and for personal circumstances; > ½ of children reported mental health problems; 62% of parents reported mental health problems—reported on standard measures; 35% reported new problems with hypertension; 44% of children lacked health coverage; 29% of children were missing large number of school days). The most vulnerable are at the end of the funding pipeline and receive the least direct benefits.

Abramson and Garfield (2006) also surveyed displaced families in the Gulf

Coast post-disaster. They summarized their survey findings indicating high levels of risk for children and families including those in our service area:

- Children suffer high rates of chronic health conditions and poor access to care (34% have one diagnosed medical condition; ½ lost their medical home; 14% were not receiving needed medications; 11% of parents report poor health; 61% said health problems were more severe).
- Mental health is significant problem (half of the parents report their child as having emotional or behavioral problems; parents scored very low on standard mental health measures.
- The safety net has major gaps (1/5 of children were not in school regularly; 44% of caregivers lacked health coverage)
- Displaced families lost stability, income, and security (a reported 3.5 moves on average in past year; employed caregiver went from 67% to 45%; less than ½ report feeling "safe"; 72% reported financial needs w/no solutions.

Forums were held that were sponsored by the Center for the Advancement of Children's Mental Health (2006)—Columbia University School of Public Health with support from Latham & Watkins Law Firm in June and August of 2006 in New Orleans. This collaborative group of children's experts described their group as a KIDS (Kids in Disaster Situations) Alliance. The forum was composed of key leaders in children's well-being and this group identified key problems facing children in our service area: widespread emotional problems of children (mood disorders; anxiety disorders); and increased suicide risk among adults.

Substance abuse problems may spike shortly after disasters, but tend to level off within a year. However, youth risk for substance abuse is well documented as a planning need for the wellbeing of youth. The substance abuse prevention plan for Louisiana (State of Louisiana, July 13, 2006) highlights some of the reason for inclusion of this problem in a comprehensive plan for youth mental health:

- 27% of LA students report drinking alcohol by the 6th grade; 55% of 8th graders report having drunk alcohol in the prior 30 days.
- 30% of all 12th graders report binge drinking.
- Between 1990/2002, fatal alcohol crashes in LA were the highest in the nation.
- 26.2% of youth report using tobacco.
- Death rates from drug overdoses in Louisiana was the highest in the nation from 1999-2001.
- 30% of all property crimes are attributed to drug use.
- Orleans Parish has higher than the state average for alcohol and drug use.
- There are data gaps (and suspected service gaps) due to post-Katrina conditions in affected parishes.
    - Recovery plan recommended by the group for the affected areas: protect affected areas from financial implications; develop communication plans; maintain and secure data; do on-going needs assessments; modify scope of services in contracts; fast-track contract changes; and link to statewide disaster planning.

It is difficult to quickly assess the rates of disorders for children and youth following a

disaster but estimates range from 20% to 68% of children experience emotional and behavioral problems secondary to disaster trauma (Bendsen, Blair, Holandez, Lutwick, Parkes, Sagness et al., 2007).

The Kaiser Family Foundation (2007, May 12, 2007) reported on survey data of 1,504 people returned to Orleans, Jefferson, Plaquemines and St. Bernard parishes. They reported baseline data which they plan to resurvey people over time to examine changes in attitudes of people living in the area. They reported key opinion indicators:

- 50% reported their finances suffered; 13% reported being denied legitimate claims on insurance coverage.
- 17% reported lost jobs or underemployment.
- 37% reported major life disruptions (17% reported being forced to move; 14% reported having lost a close friend due to the storm).
- 36% reported health access barriers (22% report deteriorated health; 18% reported harder to access regular sources of care).
- 23% reported psychological stress (17% reported temper problems; 14% reported marital problems due to storm; 10% reported alcohol problems after the storm.
- 34% (drop from 65% before the storm) reported being satisfied with their quality of life (25% in Orleans Parish).
- 16% report mental health problems; 4% report their child has mental health problems.
- 75% reported feeling they increased ability to cope after the storm.

The survey data suggest needs are substantial, especially in New Orleans:

- 77% report them or their children experiencing critical challenges in key areas of life.
- 52% of those in Orleans Parish reported multiple challenges in key areas of life (compared to 41% in Jefferson Parish).
- 43% reported chronic health or disability issues.
- 27% reported they lost access to their health care delivery system.
- 42% of those who rely on public transportation reported health care access burdens.
- 32% reported having a child with serious health and disability problems post storm.
- 27% reported serious employment related problems.

The survey also noted that African Americans stand out disproportionately impacted by the disaster and aggrieved by the rebuilding process:

- 59% reported their lives as disrupted (compared to 29% of Whites).
- 58% reported living in flooded areas with more than 2 feet of water (compared to 34% of Whites).
- 47% reported financial declines (compared with 32% of Whites).
- 56% reported housing costs gone up substantially (compared with 42% of Whites).
- 72% reported health care access problems (compared with 32% of Whites).
- 50% reported relying on emergency room care (compared with 15% of Whites).
- 26% reported difficulties traveling for care (compared with 5% of Whites).
- 55% believe they are given worse opportunities for rebuilding than Whites (compared with 19% of Whites believing African Americans receive better opportunities).
- 26% of African Americans report declined mental health while 18% of Whites did so.

The survey makes a strong statement from the voices of those returned to the area that the hurricane and flood disaster has pervasively impacted the quality of life of people living here, and secondly, the survey confirms immense and immediate needs.

In summary, the service area has been significantly impacted by Post-Katrina influences, and planning for the well-being of children and youth occurs in this context. This context drives the need for planning and care coordination.

VULNERABLE AND AT RISK YOUTH AND THEIR FAMILIES IN THE LA-Y.E.S. SERVICE AREA

Planning for the mental health and well-being of children and youth includes all children. Post-Katrina, all local and displaced children and youth have exposure vulnerabilities. Some children and youth are more at risk given a range of social and structural vulnerabilities. In this section, we briefly summarize some of these vulnerabilities. Public social responsibilities require those most vulnerable to be at the core of planning for public health and social services. When public services are in jeopardy, the most vulnerable are the most harmed.

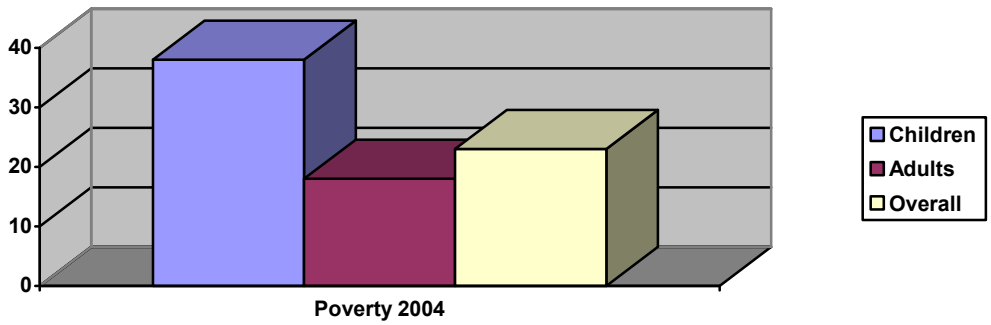
One of the most critical pieces of information to guide us in thinking about vulnerable and at risk youth is to remember from the epidemiological data (comprehensively described in research summaries from Fran Norris) is that we need to make sure parents are doing well because the better parents cope with disasters, the better children cope. Gurwitch and Silovsky (2005) developed guidelines for parents and teachers on what to expect after trauma. These are available for printing and sharing with families, teachers, and other helpers. They address possible reactions to trauma for elementary, middle school, and high school youth.

The Annie E. Casey Foundation's "Kids Count" (2006) report summarizes how Louisiana youth are particularly vulnerable relative to national data on all youth.

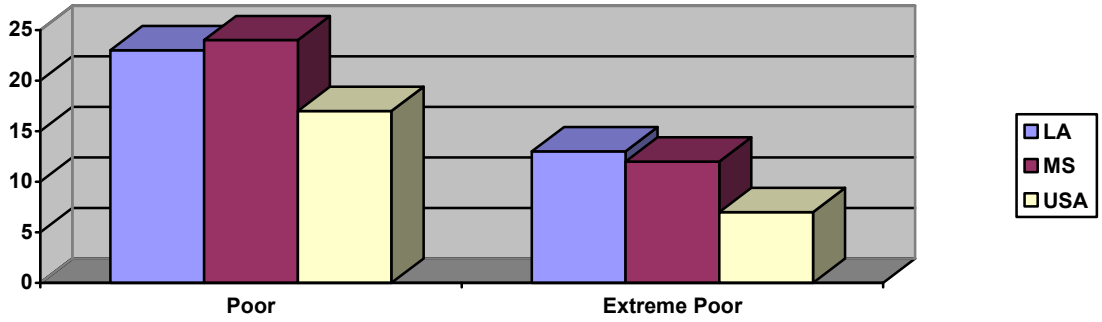
- Louisiana ranks 49 of 50 states on key children's variables
  - 10.3 deaths per 100,000 births/7.0 nationally
  - 10.4 low birth weight babies born per 100,000/7.8 nationally
  - 35 child deaths per 100,000/21 nationally
  - 30% of children live in poverty/18% nationally
  - 15.4% of children uninsured/77% were eligible for LaCHIP.

The National Center for Children in Poverty (2007) also describes some of the dimensions of youth vulnerability as illustrated in the next few tables. The first table shows the overall poverty rates in Louisiana. This data is prior to the disaster. These data figures on poverty illustrate the extent of vulnerabilities prior to the added burdens brought on by the disaster.

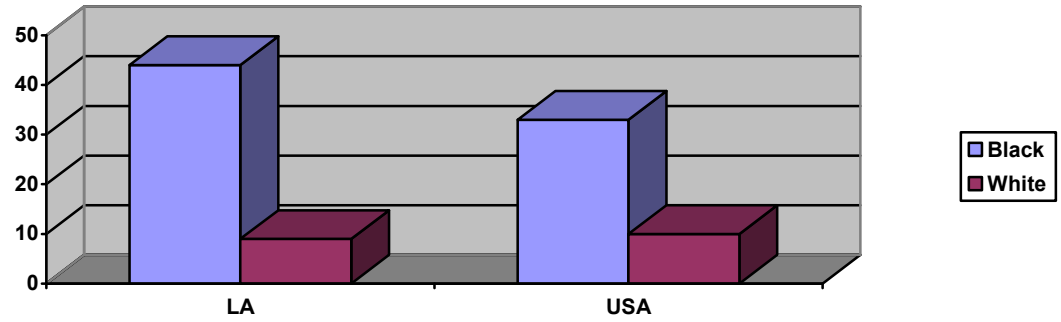
Overall poverty percentage rates for 2004



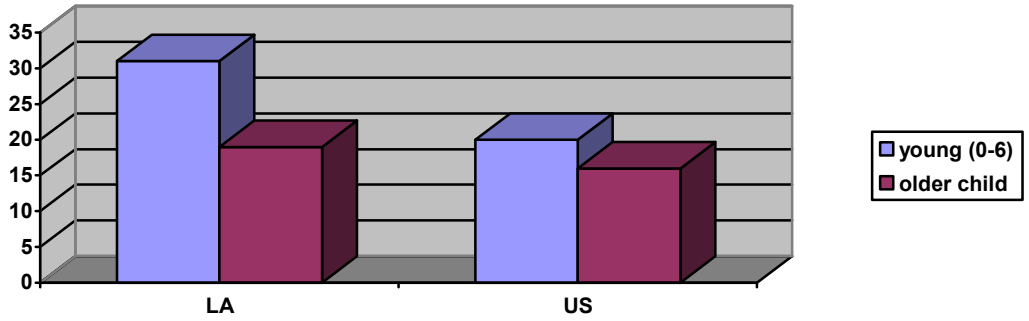
Louisiana has among the highest percentage rates of extreme poverty in the nation



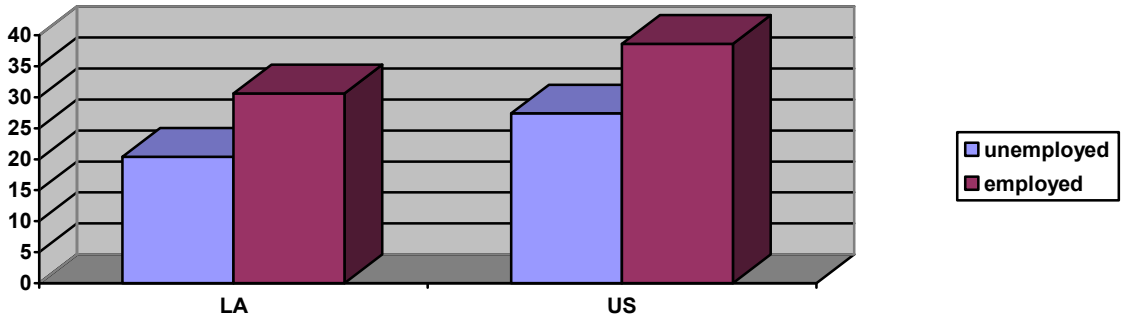
Child poverty percentage rates in LA and USA by race



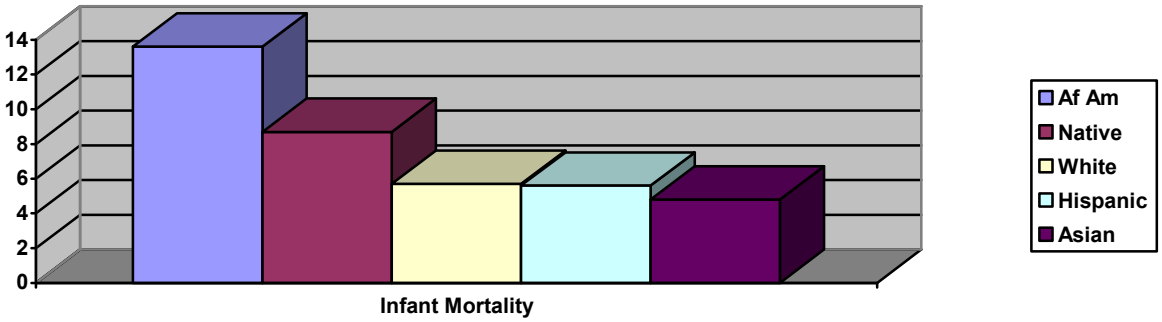
Percentage of younger children in LA and US that live in poverty



Percent of families that experience high percentage rates of unemployment/underemployment



Incidence of infant mortality in Louisiana (Rates per 100,000)



Health disparities indicate further risks for vulnerable youth and their families. The Kaiser Family Foundation (2007) reports some recent data on infant mortality, diabetes mortality, and AIDS cases (per 100,000). They also report percentages of those in poverty, those receiving Medicaid, and those uninsured.

Incidence per 100,000 of selected health variables and percentages of risk variables by race

Health Variable	**LA: White**	**LA: Black**	**LA: Latino**	**LA: All**	**US: White**	**US: Black**	**US: Latino**	**US: All**
Infant Mortality	.069	.139	.045	.098	.057	.136	.056	.069
Diabetes Mortality	30.3	73.4	40.8	40.8	23.9	49.2	21.5	25.3
AIDS Case Rate	8.1	64.0	17.3	21.2	7.2	68.6	23.3	14.0
% in poverty	14.8	39.7	Na	23.1	11.6	33.0	29.0	17.3
% with Medicaid	9.8	27.4	Na	16.0	9.3	26.2	21.6	13.5
% Uninsured	16.3	27.0	Na	20.2	13.2	20.9	34.3	17.9

Zuckerman and Coughlin (2006) also report "long before the onslaught of Hurricane Katrina or the chaos of evacuation, New Orleans' social structure was failing". They summarized low health outcomes in the region. According also to the United Health Foundation (2004), Louisiana ranked lowest overall in the country for health outcomes. Zuckerman and Coughlin report Louisiana ranks one of the five worst states for infant mortality, cancer deaths, prevalence of smoking, and premature death. It is in this context of health care that children's mental health care must be examined. They also note that families in Louisiana are more likely to require hospitalization and to need crisis health care. Those without insurance coverage (the highest rates in the nation) were most likely to receive care in public facilities. They report that low income children in Louisiana have lower private health coverage (26.1% compared to nationally 30.7%) and more Medicaid/LA-CHIP (51.3% compared to 44.3% nationally). Zuckerman and Coughlin recommended both short term recommendations to manage the crisis and longer term solutions to focus on infrastructure reforms.

Poverty is also impacted by the exposure of businesses to the Katrina-related disaster (LA Recovery Corporation, 2007):

- One year after the storm: LA experienced a 2.3% decline in businesses

- One year after, in the five parishes in Southeast LA, there was a 25.6% business failure rate.
- One year after, there has been a 13.3% decline of prior businesses in operation one year later (Orleans with a 26.7% decline; St. Bernard with a 53.9% decline; St. Tammany with a 2.6% increase).

Risks to vulnerable children are impacted by the opportunity structures in the communities in which they and their families live. Not only youth are at risk, but disparities in risk threaten some youth more than others. The National Institute for Health Care Management Research and Education Foundation (February 2007) provides an example of this disparate risk:

- Disparities are found by race and ethnicity as well as socioeconomic status (SES); SES does not account for all the differences.
- Among poor children, 3 times more self-report "poor health"; they have half as many doctor visits (same as among racial/ethnic groups).

Homeless youth are also at risk. Homelessness among children and youth at a national level indicates this is a vulnerable population needing to be considered in care planning.

The federal Housing and Urban Development reports annually on homelessness. The latest report on homelessness (HUD, 2007) indicates:

- HUD estimates in its 2006 annual report on homelessness that on any given day, 335,000 people are homeless. Nearly ¼ of all sheltered homeless people are 17 years of age or younger.

A recent report by Ray (2007) on homeless youth also identifies vulnerable youth. Estimates range from 575,000 to 1.6 million youth homeless (using a very broad definition of homeless or at risk of homeless) at any time in the US. It is estimated that between 20 to 40% of homeless youth are lesbian, gay or transgendered (lgt) (ranges from 115,000 to 640,000 youth). Approximately 26% of them were kicked out of homes over "coming out" issues and 33% experienced violent assaults when coming out. Approximately 10 to 20% of homeless youth self-identify as having substance abuse problems, and being lgt confound problems in securing shelter and treatment. More than 50% report engaging in "survival sex". Lgt youth are 7 times more likely to be victimized by crimes than other homeless youth and if incarcerated, are estimated to be over-represented among youth sexually assaulted by other youth and staff in institutional settings. Ray (2007) estimates that 1 in 5 transgendered youth are at risk for homelessness.

There is an increased risk for HIV infection among youth due to traumatic stress: increases risk-taking behaviors; developmental threats; disproportionate impact on already vulnerable populations; and the combinational effects of high rates of other risks for youth in Louisiana. The Kaiser State Health Facts (2007) describes this risk:

- LA AIDS Cases: White 27.7%; Black 59.7%; others 2.4%
- LA is 15th in the number of pediatric AIDS cases (131).
- The LA rate for AIDS cases is 21.2/100,000 with a national rate of 14.2/100,000).
- LA is rated #4 for Teen Deaths (accidents, homicides, suicides): 97/100,000 with a national rate of 66/100,000).
- LA is rated #7 for Child Deaths (28/100,000 with national rate of 21/100,000).
- LA is rated #2 for Infant Mortality (10.3/100,000 with a national rate of 7/100,000).

- LA has the second-lowest rate of children (ages 1-17) who received help for emotional, developmental, or behavioral problems in the nation (44% compared to 59% nationally).
- LA has the 7th highest teen birth rate (56.2/100,000 compared nationally at 41.1/100,000).

Data from the National Adolescent Health Information Center (2007 Fact Sheet)

- (2004 data): Leading Causes of Death Nationally for ages 10-24 reports:
  - Motor vehicle 31.3%; homicide 14.2%, suicide 12.3%, unintentional injuries 14.2%; all other 28.1%.
  - Homicide rates for males per 100,000 (white—3.4; Hispanic 20.1; Black 53.8).

Good planning for all youth in need of support from their families and communities is particularly responsive to the needs of the most vulnerable youth.

THE SAFETY NET FOR LA-Y.E.S. YOUTH

The safety net provided for youth influence how youth manage their problems. This section briefly describes some aspects of the safety net for youth in the LA-Y.E.S. service area. The Louisiana Office of Mental Health (OMH) developed the Louisiana Community Mental Health Services Block Grant (2007) which provides a component of safety net guiding the emotional and behavioral well-being of youth in the LA-Y.E.S. service area. Some key descriptive features in the report indicate risks and vulnerabilities as well as structural supports:

- In 2005/2006, OMH reported providing services to 4,886 children through Medicaid funding. OMH reports of the 946,926 youth, (.5% of the states children between 0-17). OMH estimates 9% of the state's children have a serious emotional disturbance. Thus, they estimate 4.17% of the states youth with serious emotional disturbance receive any kind of services they provide.
- As of June 2006 (Post-Katrina), most parishes reported a serious lack of providers. For example, the MHSD reported having 10 FTE psychiatrists available, no child psychiatrists. JPHSA reported having 9 psychiatrists, 2 child psychiatrists. Other parishes in the service area report having none. (Anecdotally, other programs report difficulty in recruiting related mental health providers for staff or contract services and those that have these providers report high turnover among its vulnerable professional staff).
- "In Louisiana, only 7-14% of children with mental health disorders are receiving services and only 13% of the Office of Mental Health's budget is spent on children's services."

A report called "A Roadmap for Change" prepared for the Department of Health and Hospitals provides other data on the mental health safety net in Louisiana:

- Youth (and adults) with mental illness are drastically unemployed and underemployed in Louisiana.
- Mental health services for youth (and adults) and their families are woefully inadequate for those coming through the criminal justice and family court systems.
- Louisiana has an inadequate financing structure to ensure access to appropriate mental health care.

- Louisiana currently makes very limited use of evidence-based and best practices.
- Louisiana lacks alternatives to traditional crisis services thus creating an even greater shortage of the state's acute, inpatient bed capacity.
- Louisiana is 38th in the nation in terms of suicides.
- The capacity of the mental health programs are challenged in meeting the needs of its diverse populations.
- Louisiana is facing a serious shortage of professionals trained in delivery of evidence-based or best practices.
- Louisiana lacks a system for assessing behavioral health needs at the community level.
- Mental illness and substance abuse problems contribute to a serious homelessness problems in Louisiana.

Various OMH programs provide services to children and their families

- Louisiana Spirit (crisis and follow up services for traumatic stress).
- Early Childhood Supports and Services (promotes a positive learning environment for learning, growth, and relationship building. It provides screening, counseling, violence-prevention, care management, behavioral modification, parent support, and emergency interventions).
- Louisiana Youth Enhanced Services (see introduction).
- Juvenile Justice Reform (HRC 0005 and HB 1372) commits the Office of Mental Health to work with incarcerated youth as "restoration service providers".

The Community Mental Health Services Block Grant (Office of Mental Health, 2007) funds various programs for youth: school based mental health; crisis response services; in-home crisis; crisis hot line; suicide prevention; crisis/respite; crisis housing; counseling; case management; family preservation; assertive community treatment; juvenile diversion; after school/mentoring; wraparound; transportation; and multi-systemic therapy. These services are often provided through the human service districts and generally not available statewide (often only in few select parishes).

The Urban Institute provides an ongoing assessment of Post-Katrina social conditions. Zedlewski (2006) assesses the key issue of the local safety net. This report notes the most vulnerable: the elderly; people with physical and mental disabilities; and single parents out of the labor market. Rebuilding provides an opportunity to strengthen the safety net.

One way of tracking the strength of the social safety net for children and youth is to track children's spending in the federal budget. A recent analysis in "Kids' Share" (Carasso, Steuerle, Reynolds, 2007) in an Urban Institute report indicate:

- From 1960 to 2006, children's spending rose only from 1.9% to 2.6% of the federal budget; other entitlements rose from 2.0% to 7.6%; as a percent of federal domestic spending, children's spending declined from 20.1% to 15.4%.
- Federal spending tends to target the very poor (increased from 11% to 61% of children's spending) with steep phase outs; less middle-class support; tax programs decreased (from 68% to 7%).

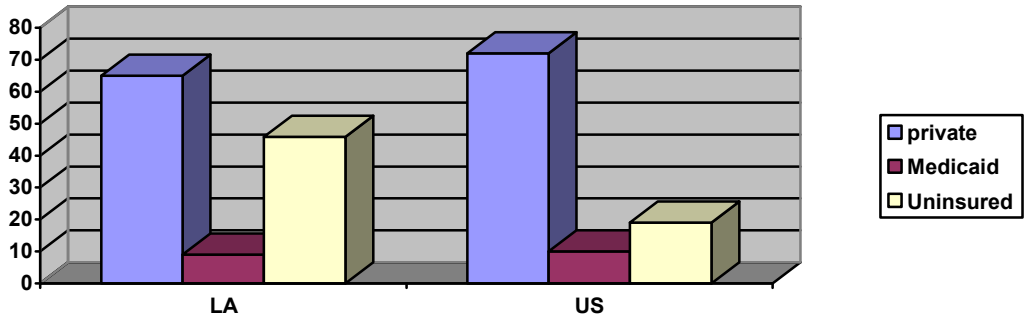
The Children's Health Campaign (2006) notes gaps in the safety net around coverage for basic health care (which reflects mental health coverage):

- There are 1,200,000 children under 19 years of age in LA; 135,000 are estimated to have no health coverage;

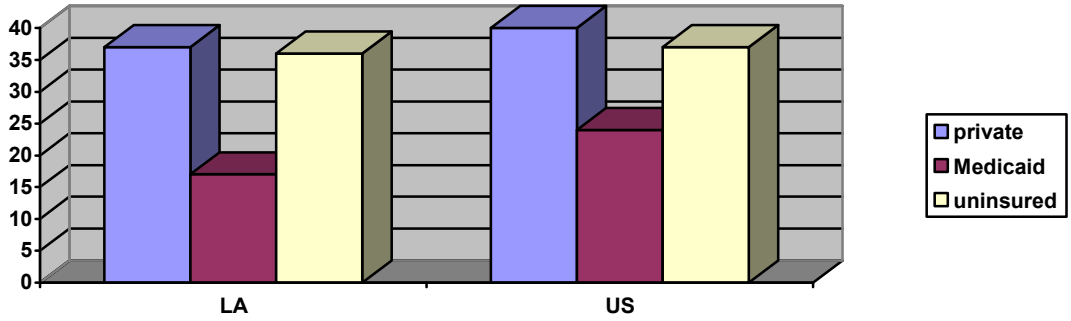
- 11% of Louisiana children have no coverage (78% of low income children have no private coverage)
- 79% of them have working parent(s)
- 9% of children under 6 are uninsured (risking a healthy start on life)

The Kaiser Family Foundation (2007) reports on the safety net for women who provide the care for most vulnerable children in Women's Health Policy Facts. This data is illustrated in the following charts:

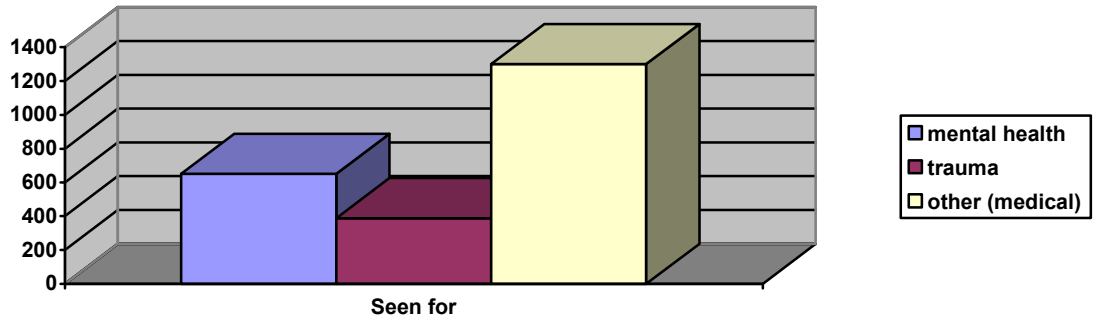
- Percentage of health insurance coverage for women



Percentage of health insurance coverage for low income women

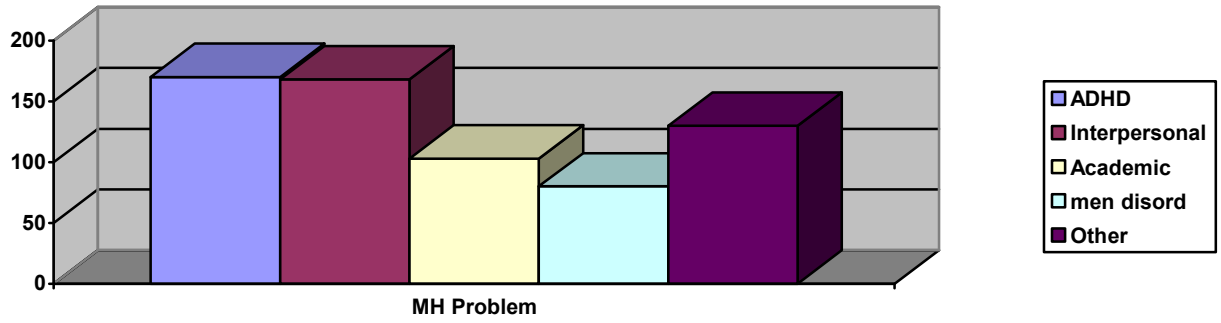


Jefferson Parish School Based Health Clinics: Numbers seen in clinics—Bunche Site



One key way children's mental health needs which are directed through community-based provider networks is through the school-based clinics. A report form one of these clinics gives a snapshot of the mental health of youth in our service delivery area. The Jefferson Parish School Based Health Clinics (2007) reports "Mental Health Related Visits—Bunche" site.

Number of mental health related problems reported at the School Based Clinic



The safety net provides supports for vulnerable youth yet gaps exist in care availability and access. The mental health safety net includes a variety of providers financed through multiple funding mechanisms. A broad overview of the mental health safety net (Bendsen, Blair, Holandez, Lutwick, Parkes, Sagness and others, 2007) describes some of the essential components of these inter-related care sources. The following table summarizes their descriptive list. It is not meant to include all possible services—just some key noted ones.

Children's' Mental Health Related Services (January 2007)

New Orleans Adolescent Hospital	Two walk in clinics in New Orleans; one planned for Plaquemines Parish
Nurse Family Partnership	Prenatal and early childhood home visits for some low income women
Early Childhood Supports and Services (ECSS)	Infant mental health providing screening, evaluation, referral and treatment
Louisiana Spirit	Crisis counseling; CBITS in schools
LSU Health Sciences Centers	Outpatient clinics; traumatic stress screening
Metropolitan Human Services District	Outpatient clinics
Tulane University	Outpatient clinic
Non-Profit Providers (Catholic Charities; Jewish Family Services; Celebration Church Counseling; Counseling Services of New Orleans; McFarland Institute; Mercy Family Center; Chambers Counseling Center; Trinity Counseling; Children's Bureau; Common Ground; Family Services)	Various counseling approaches and models;
School Based Clinics	(5 clinics planned in Orleans; 4 in other areas)
Project Fleur-de-Lis (Mercy Family Center; Catholic Charities; Daughters of Charity)	Counseling in Catholic Schools and some Charter Schools
VIA Link	211 system
Louisiana Public Health Institute	Coordination activities; workforce development
Southern University at New Orleans/Louisiana Youth Enhanced Services (LA-Y.E.S.)	Workforce development (post-masters certificate in treating child traumatic stress)
LA Health Care Redesign	Governor's Task Force—mental health access

The United Way of Greater New Orleans funds a variety of service areas that support mental health. Post Katrina, a re-examination of priority areas shifts support areas, but the following table provides some examples of these related supports. These supportive programs promote family wellbeing and reduced stress on vulnerable families as well as promote access to care.

Service Area	Program Examples
Child Care	Faith-based organizations; community centers
Housing/Shelter	Battered women's programs; emergency shelter; rental assistance
Health	Disorders (e.g., AIDS; hearing impaired; substance abuse)
Mental Health	Prevention; counseling; evidence-based models of care; crisis services; care management; special populations
Community Development	Neighborhood building; data infrastructure
Youth Development	Advocacy; emergency assistance; mentoring; support for at risk youth; prevention

Families and children do better when their comprehensive needs are adequately addressed. This improves a wide range of psychosocial features in the lives of the families as well as supports broad public improvement. Funding of comprehensive care for addressing the youths with mental health problems is demonstrated to be effective through evaluation of programs across the country (SAMHSA, 2007). In evaluation of systems of care services which provide wraparound services to families who have a child with emotional and behavioral problems, positive findings are numerous:

- Reduced costs due to fewer days in inpatient care.
- Decreased utilization of inpatient care.
- Reduced arrests result in per-child cost savings.
- Mental health improvements sustained.
- Suicide-related behavioral were significantly reduced.
- School attendance improved.
- School achievement improved.
- Significant reduction in placements in juvenile justice.

This national data provides a reason to understand why the safety net needs to be rebuilt as an urgent priority to the devastated areas of the area.

ACCESS TO CARE BARRIERS

A variety of access barriers exist for the youth and their families. This report summarizes a few examples of these barriers, some of which are related to post-disaster conditions and as well are related to structural characteristics of the communities in which families and youth live.

A recent article by the Times Picayune (Maggi and Moran, April 23, 2007) reports on the "mental health crisis" in the unavailability of psychiatric beds (all persons) in the Metropolitan

area (Orleans, Jefferson, and St. Bernard Parishes). Data includes both adults and youth. They provide the following data:

Parish	Psychiatric Beds	Before Katrina	Post-Katrina
Orleans	Bywater Hospital	20	0
	Charity Hospital	100	0
	Community Care Hospital	38	24
	DePaul-Tulane	52	0
	Kindred Acute Care	25	0
	Lakeland Medical Center	11	0
	Methodist Hospital	14	0
	New Orleans Adolescent Hospital	30	35*
	Psychiatric Pavilion of New Orleans	24	24
	Touro Infirmary	48	0
	Veteran's Affairs	25	0
	Orleans Parish Subtotal	**387**	**83**
Jefferson	Advanced Care	12	12
	Behavioral Health of Kenner	NA	8
	East Jefferson Hospital	33	34
	Generations	20	0
	Ochsner	16	12
	River Oaks	52	49
	West Jefferson Medical Center	16	16
	Jefferson Parish Subtotal	**149**	**131**
St. Bernard	Chalmette Medical Center	16	0

*New Orleans Adolescent Hospital has the only designated beds for youth prior to Katrina. Post-Katrina, these beds are for both children and adults.

As a result of the catastrophic loss of beds (more than 300) in Orleans and St. Bernard Parishes, the Times Picayune (Maggi and Moran, April 23, 2007) reported the state of mental health in the area as in crisis. They ran the headline for their featured article as "Mental Patients Have No Where to Go". Law enforcement are reported to have to bring in psychiatric patients for evaluations and wait with them because existing facilities (those that currently take crisis cases) do not have the capacity to handle crisis cases and so police are required to stay with patients during the entire process. This is generating a crisis in law enforcement time and resources. Many facilities are on a list to accept crisis patients, but police are focusing on sites where they do not have to spend exorbitant time, and thus are basically declining to bring in persons in mental health crisis. Patients are reported to sometimes spend days in the emergency room because of a lack of beds for them. Hospitals are reporting crises because they are not able to handle medical crisis because their emergency rooms are filled with psychiatric patients with no place to go. Without treatment, many end up in jail. The criminal justice system says they are "paying for the breakdown in the mental health system". Presumably the detention facilities are picking up the cases. Prior to Katrina, police averaged 330 crisis calls per month for persons with mental health problems—Post Katrina the rate is 207calls per month. Orleans Parish Prison reserves 60 beds for "psychiatric" prisoners. The Orleans Parish Prison spends 20% of their pharmaceutical budget on psychotropic medications. Because of the collapse of the public out

patient care in the area, the in pressures on in patient care is intense and crippling. The newspaper article quoted the Medical Director of the Office of Mental Health as saying "**The thing about hospital beds is you only need them when your outpatient services have failed. We do not have the services to prevent hospital visits".**

A General Accounting Office (GAO, 2006) report (Post-Katrina) summarizes some of the access issues:

- 80% decline in hospital beds post-Katrina; close of Charity/LSUHSC; of the 160 clinics operating before/19 remain operating post at 50% capacity; loss of 6,000 health professionals; 100 community health centers harmed—7 destroyed.

A Times Picayune Report (March 13, 2007) provides information on mental health care:

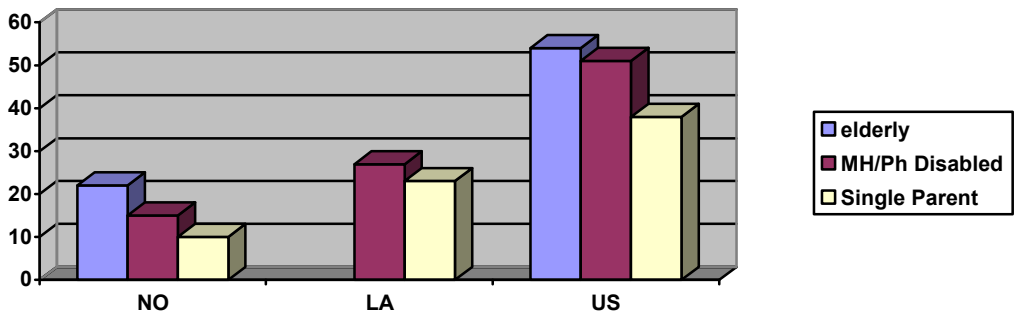
- 211 beds for men; 24 for women; 25 coming on line soon
- Times-Picayune Report March 12, 2007, p. A-5: 18 community-based health care clinics in operation in the greater New Orleans area (both public and private).
- The Greater New Orleans Community Data Center reported 11 hospitals open in the Greater New Orleans area as of March 30, 2007 (MCL/NO; Tulane; Ochsner Baptist; Touro; Children's; West Jefferson; Ochsner West Bank; Ochsner; East Jefferson; Tulane/Lakeside; and Ochsner Kenner).

The Center for the Advancement of Children's Mental Health (Mailman School of Public Health—Columbia University, 2007) also report consensus statements based on community forum information:

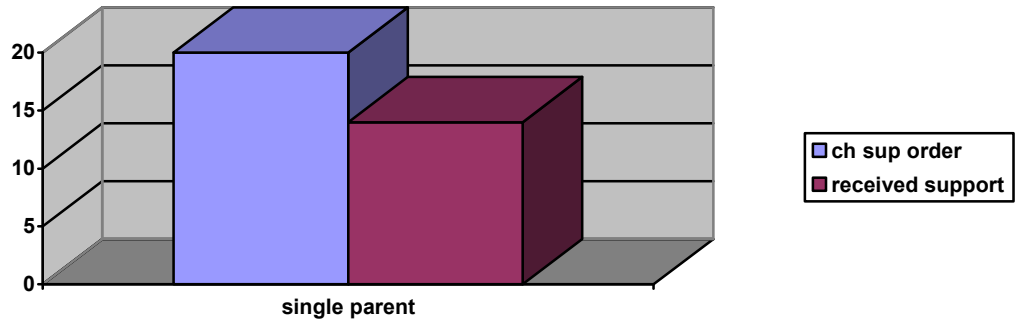
- There is a lack of centralized information on mental health needs or resources.
- There is a lack of communication and coordination between providers and community.
- There is a lack of treatment capacity (resources; human resources).

The Urban League (Zedlewski, 2007) reports poverty level percentage among vulnerable populations; (about 10% of population in NO w/disabilities; about 32,000 pre-Katrina); LA spends less than other states on its safety net (ranked 48 of 51). (E.g., LA does not supplement SSI payments for those with disabilities; does not have general assistance program for disabled). Though high rates of poverty, less than 3% in New Orleans receive public assistance; and 11% food stamps (7% nationally). The report indicates 20% of the children in New Orleans experience ongoing hunger (2007). Nearly 50% of poor families paid own rent for housing (compared to 34% of poor in Baton Rouge); rent equaled 40% of income—16% in region.

Percentage of poverty of at risk groups (elderly; disabled; single parents) in LA

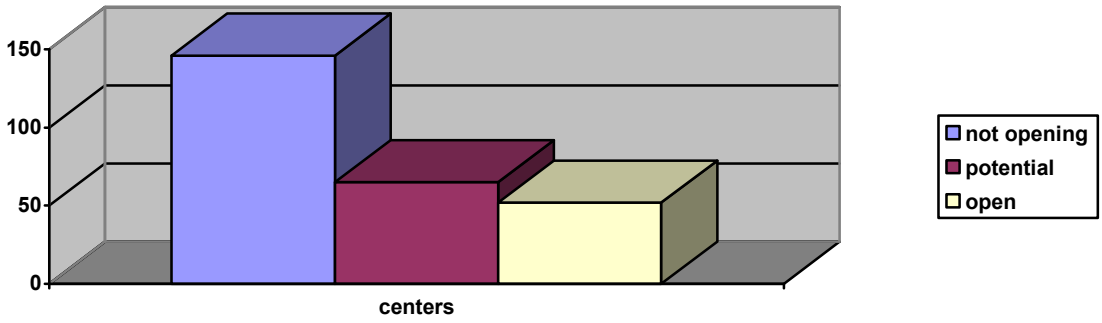


Percentage of families receiving child support in LA

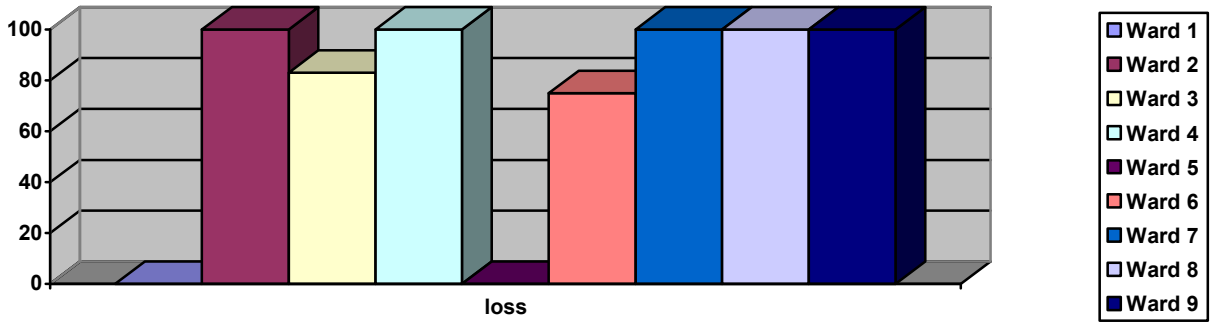


In an examination of child care needs Post-Katrina, Shores and others (2006) reported no child care "plan" exists (as of June 2006) for children in the New Orleans Metropolitan area. The June 2006 survey showed: 56% of prior centers were not re-opening; 25% were possibly reopening but not open; and 20% were open. This is an 80% loss of slots—closures and loss of spots are far outpacing the returned population. Their analysis indicated that 54% of neighborhoods have lost "all" slots. The following charts illustrate the loss.

Number of child care centers



Number of child care center loss Post-Katrina



The Greater New Orleans Community Data Center (February 26, 2007) also reports on the loss of child care facilities in Orleans Parish.

Child Care Facilities in Orleans Parish	Numbers
Open pre-Katrina	273
Re-opened	80 (29%)
Closed	193 (71%)
New Facilities	4

Access to child care in the metropolitan area is greatly limited.

The Greater New Orleans Community Data Center also reports on the limits on school space in Orleans parish as of January, 2007: Status of Public Schools in Orleans Parish. This data is indicated on the following table.

School	Numbers
Recovery School District	19
Orleans Parish School Board	5
Algiers Charter School Board	8
Independent Charters	23
Total Schools	55
Number closed	77

The Times Picayune (April 30, 2007) provided a summary comparing school districts in Orleans and their special education populations.

	East Bank Independent Charters	New Orleans Public Schools	Algiers Charter Schools	Recovery School District
% of schools serving students w/mental disabilities	59.1%	100%	100%	100%
% of schools serving students w/emotional disturbances	59.1%	80%	100%	94.1%
% of schools serving students w/multiple disabilities	0%	20%	37.5%	23.5%
% of schools serving students with autism	22.7%	80%	75%	52.9%
Special Education total	465	207	326	610
Total Enrollment	9,753	2,825	4,664	8,381
% of student population in special education	4.7%	7.3%	7%	7%
% of all students served by the system	38.1%	11%	18.2%	32.7%
% of all special ed. students served by the system	29%	12.9%	20.9%	39.1%
% of schools with special ed. populations above 5%	50%	100%	87.5%	88%

Critics of this approach are concerned that the East Bank Independent Charter Schools are under-serving students with disabilities and mental health problems which not only limits access to families but limits choice.

Another key access point for low income families (generally excluding families of the working poor) is through Medicaid spending. The following tables provide a brief look as some aspects of access to care through Medicaid in the LA-Y.E.S. service area. The data from these tables are for the area just prior to the disaster (Medicaid Annual Report, 2004/05.

Medicaid enrollment as % of population in LA-Y.E.S. service area

Enrollment in Parish	**Medicaid (% of all children)**	**La-CHIP (number enrolled)**
Jefferson	22	14,380
Orleans	33	15,821
Plaquemines	22	901
St. Bernard	22	2,132
St. Tammany	16	6,030

State Medicaid Enrollment by Age and Payments

Children (0 – 20)	**Percent**
Enrollment (statewide total of who enrolled)	65%
Payment	24%

Some of the most vulnerable youth with serious emotional and behavioral disorders access care through the juvenile justice system. Data on the population of youth committed to the juvenile justice system at the end of 2006 were provided by the Office of Youth Development (2007).

Parish	**Secure Custody**	**Non-Secure Custody**	**Parole**	**Probation**	**Total**
Jefferson	49	31	18	102	200
Orleans	28	6	29	163	226
Plaquemines	2	2	0	8	12
St. Bernard	2	0	1	2	5
St. Tammany	18	14	1	189	222
State Annual Total	450	663	182	3407	4702

The population in secure facilities in 2007 was 77.9% African American, 20.4% Caucasian, and 1.7% other. The population was 93.7% male. They were incarcerated for: violent crimes (41.4%), drugs (11.2%), property crimes (30.2%), and other (17.3%). The most likely age was between 16-17 years old.

In March of 2007, the Office of Youth Development (2007) reports a variety of placements for youth to address a range of needs.

Office of Youth Development Program (Statewide Data)	**# of Youth**	**Yearly Average**
Community Diversion	104	55.2
Day Treatment	370	293.9
OYD Foster Care	16	14.2
Group Home	190	198.8
Independent Living Halfway Home	12	13.5
Intense In Home	58	59.0
Private Psychiatric Facility	8	7.5
Residential	167	209.7
State Hospital	10	9.9
Substance Abuse	49	38.6
Total (including all in custody)	4755	4710.9

The following data summarizes some of the data related to access to care for these vulnerable youth.

The Coalition for Juvenile Justice (2000) reported some general data which provides a context for this access to care issue.

- 50 to 75% of incarcerated youth have diagnosable mental disorders.
- 1 in 3 in need of mental health care receives it.
- 36% of care givers say youth is incarcerated to get mental health care.
- Care reduces recidivism by 80%.
- 75% of incarcerated youth in juvenile facilities are without care resources.
- 67% of all incarceration costs go for care of mental health problems of the youth.
- African American youth are less likely to receive care and are frequently not diagnosed and misdiagnosed.
- 75% of girls incarcerated have been sexually abused (NB: from a presentation at Southern University at New Orleans sponsored by SAMHSA Dr. Linda Tempton reported that girls have higher rates of disorders than boys and receive less treatment).
- More than ½ of girls incarcerated have attempted suicide.

In a related report called "And Justice for Some: A Report on African Americans and Juvenile Justice", the National Council on Crime and Delinquency (2006) report on disparities in access for African American youth. They note that African Americans youth are:

- 16% of population.
- 28% of juvenile arrests.
- 30% of referrals to juvenile court.
- 37% of detainees.
- 34% of youth formally processed through juvenile court.
- 30% of adjudicated youth.
- 35% of youth formally waived to criminal court.
- 38% of youth in residential treatment.
- 58% of youth admitted to state adult prison.

The reform movement for juvenile justice provides an excellent opportunity for those involved in youth services to address the integration of mental health and youth development into service delivery for all youth, and especially supporting the most vulnerable youth such as those whose portal of entry into care may be the juvenile justice system.

Many vulnerable youth enter care through the child welfare system. This system was gravely impacted by the disaster. In 2005, the Office of Community Services (2007) reported that 7,145 children were in foster care in Louisiana. They reported 656 of these youth were provided services in institutional settings (residential facilities, psychiatric hospitals, or medical facilities). An estimated 2,300 foster children (already traumatized) were displaced by Katrina in Louisiana. These children need to be integrated into the service plan for the LA-Y.E.S. area.

Children and youth transitioning out of the child welfare system are important considerations in service planning and largely not integrated into care planning in the area. A key element of services is transitional services for youth with serious emotional and behavioral health problems. Davis, Geller, and Hunt (2006) outline some of this populations needs.

- (Getting GED; entering post-secondary education; employment help; preparing for independent living; help with adult relations; obtaining age-appropriate mental health services; transition planning).
- Reviewed both adult and children's services: fewer than 4 states provided any of these services. When available, access covered less than 8% with adult services and 22% of youth services.

This very vulnerable population is not addressed well nationally nor integrated into the service delivery system locally.

PART II

REPORT RECOMMENDATION SUMMARIES

This report provides a guide for ongoing examination of the systems development and reconstruction of the service delivery network for LA-Y.E.S. and the families and youth serviced in the service parishes (Orleans, Jefferson, St. Bernard, Plaquemines, and St. Tammany). These recommendations come from a variety of community development, reconstruction and planning efforts over the past year in our service delivery area. These plans come from local professionals, families, and advocates who have brought resources and key informants together to address the needs of children and youth in our area. This has been supported by various outside sources, including reports from foundations, professional groups, and public policy advocates. This set of recommendations have been reviewed locally and involved professionals in the public and private sectors in a process of identifying elements of plans that would help families and youth regain lives in new and changed environments. Through a process of involving local stakeholders (families as well as providers and advocates as well as public service agencies), this list of recommendations are included into the conversation about a plan for children's mental health in the LA-Y.E.S. service area.

The following section summarizes recommendations from a variety of sources all thought to be important to this discussion of the development of a plan for improving children's mental health services in the LA-Y.E.S. service area. These areas are bulleted to provide the range and depth of the recommendations and yet to provide a concise overview of them. In earlier sections of this report, some of the data supporting their recommendations are provided. References to these reports are provided at the end of this report. The recommendations are not listed in order of priority.

SUMMARIES OF RECOMMENDATIONS: VULERABLE YOUTH AND IMPROVING THE SAFETY NET

- National Center for Disaster Preparedness—NCDP, (2006)
    - Economic development programs should emphasize job retraining, skill building, and home ownership.
    - Need community-based care managers to impact new neighborhoods, new schools.
    - Need mechanisms developed supporting "community engagement".
    - Maximize Medicaid/La-CHIP enrollment.
    - Assure ongoing supports for mental health engagement.

- Gurwitch and Silovsky, University of Oklahoma Health Sciences Center, 2005
    - Recommended guidelines for assessing the impact of the trauma on youth in elementary, middle school, and high school
    - Specific recommendations to parents: be a role model (since how parents cope dictates how youth cope); take care of oneself (diet, rest, exercise); give oneself time to relax; put off making major decisions as possible; focus on an optimistic outlook; and ask for help.

- Goldman (2006)
    - Given the widespread and deep impact, the response needs to be commensurate (e.g., support Head Start and Early Head Start programs—demonstrated effective; multiple RTC studies support effectiveness).
    - Programs need to be as comprehensive and community based as is the impact of the disaster.
    - Need to focus on high quality (training—educators, mental health, caregivers of trauma informed practices; evidence-based care).
    - Best responses: engage parents in interventions.

- Zedlewski (2006)
    - (Short-term safety net solutions). Food Stamp Program was one of the first responders: enrolled 900,000/$400 million in benefits after storm (reduced reapplication hurdles; feds paid administrative costs; $12 million for food banks). Need to assure easier access is maintained as programs stabilize.
    - TANF benefits after storm exempted from the "clock". Benefit levels too low to help get families on their feet ($200 average per month for family of 3). Levels of payment exacerbate problems rather than solve them.
    - Housing: need to address housing need for all poor families wishing to return…no comprehensive plan is in place.
    - (Long range safety net solutions). Need to develop permanent plan to reduce poverty among the vulnerable (including families with a child with mental health problems). Goals: increase employment; increase savings rates; reduce single-parent head of households; reduce poverty rate). Strategies: basic skills training; GED completion rates; pregnancy prevention; supportive housing for at risk families.
    - Need to provide support services to achieve goals: child care; transportation to facilitate employment/education.
    - Develop programs integrating care for at risk youth that bridge gaps between education institutions and at risk populations.
    - Include supports with housing for vulnerable families.

- Madrid and others (2006) describe lessons learned from early child mental health responses:
    - Promote family resilience (emphasis on empowerment; reunify families; focus on strengths; assist with re-integration; deal with coping and losses; comprehensive needs assessments; emphasize dignity of each family; identify special needs families and youth).
    - Identify the most vulnerable (poverty; race; lesbian/gay/transgendered; underserved; hire minority providers; focus on cultural and linguistic competence.
    - Help families resettle (link to health, mental health, and social supports—wraparound services; community-based); link to health care.
    - Mental health is key to resettlement (see NCDP guidelines above).
    - Connect those trained in trauma care with families; develop resource connections; implement human resource development activities.

- Zuckerman and Coughlin, (2006)
    - Short run needs: provide focus on potential environmental toxins; provided concerted attention to mental health trauma (post traumatic stress disorders; depression, and other psychological distress problems; make sure mental health services are available to the poor and uninsured.
    - Long range needs: expand public health insurance coverage for all people, including children through LA-CHIP; explore options in balancing public coverage with public health care; coordinate services (especially for youth) between public health, social services, and education developing an integrated system of care.
- National Institute for Health Care Management (February, 2007) makes these recommendations to reduce health disparities among children impacted locally:
    - Develop strategies to expand coverage; expand culturally and linguistically competent care; reach out to immigrants;
    - Successful health plan features: collect data on quality by at risk groups; provide provider training; focus treatments on disparities; develop "community-based approaches to delivery" (neighborhood; target populations; supports; stigma reduction; targeted education)
    - Key points: collect adequate data; train providers; plan for cultural competencies; develop public awareness; partner with community-based groups; focus on disparities: quality and cost.

- Knitzer & Lefkowitz (2006)
    - Ten strategies for helping the most vulnerable youth
        - Expand access to all low income families to child development and family support programs.
        - Provide evidence-based interventions in community-based programs.
        - Embed intensive interventions into service programs.
        - Organize service delivery by level of family risk.
        - Provide basic supports along with intensive services.
        - Develop partnerships (early intervention/child welfare).
        - Screen for and address maternal depression and other risks in health care settings.
        - Implement parenting curriculum and informal supports for higher-risk families.
        - Build community-based services.
        - Include vulnerable families in all advocacy strategies.

- National Child Trauma Network (2004)
    - Recommendations for improving access:
        - Many who get care have long histories of trauma: do early case finding and secure treatments.
        - Engage in stigma reduction activities (public information).

        - Integrate services into where children live—community-based services; school-based; community mental health clinics; hospitals; crime scenes; disaster shelters; and in home services.
        - Focus on under-served (immigrants; rural; disabled; ethnic minorities).
        - Make sure they receive effective interventions (few recommended: TFCBT; PCIP; CBITS) agency change is required: not services as usual.
        - Monitor standards of care.
        - Make sure affected areas have "trauma systems" work being done: focus on trauma at homes, in families, in communities—not mental health offices.
        - Develop collaborations and advocacy groups to focus on trauma informed services.
        - Do training and education for providers (at all levels): on evidence-based practices; adaptation of new treatments; provide on-going consultation; reach rural settings and minority populations (Cultural and Linguistic Competence); and runaway/homeless youth.
        - Disseminate knowledge/resource information (public information); community partners sharing.

- National Council on Community Behavioral Healthcare (2007) report: Discharged from hospitals, transitions home/Into the Community: Recommendations for continuity of care
    - Collaboration between institutions and community based providers.
    - Develop quality assurance benchmarks for related collaborators.
    - Connect families to care management.
    - Connect community providers before youth leaving institutions.
    - Educate/empower families on personal care.
    - Develop a focus on prevention of further institutionalized care.
    - Share data between agencies on care outcomes in usable and timely ways.
    - Involve families and their advocates at all levels of care.

- Ray (2007). Recommendations for Lesbian/Gay/Transgendered Homeless Youth.
    - Commitments and monitoring of faith based service providers to assure non-discrimination (staff; other youth).
    - Model programs for homeless youth identified and need to be replicated (NYC; Waltham, MA; Detroit; Ann Arbor; Denver).
    - Federal policy (reauthorization of the RHY Act; health coverage; estimate prevalence; broad enough definition to include homeless situations common to runaway homeless youth).
    - State policy (develop inclusive housing streams; provide dedicated space; do outreach to adoptive and foster homes; not criminalizing risk behaviors but provide effective interventions; expand health coverage).
    - Local policy recommendations: (require non-discrimination by providers; develop and enforce cultural and linguistic competence standards; conduct cultural and linguistic competence training).

- Shores and others (2006) Recommendations:
    - Help families in their communities (open centers near to schools that reopen).
    - Target vulnerable families (open centers in areas with low income working families); subsidize low income families w/vouchers; support centers with successful learning programs (Head Start).
    - NB: authors recommend this most highly: Build on program strengths (large scale; high impact; comprehensive; quality; responsive to families); (prioritize Head Start; Early Head Start); those already open; those close to open schools.
    - Provide technical assistance to open sites; NB: provide needed mental health services at sites.
    - Develop policies supporting "public/private" partnerships: incentives for businesses; set up opportunities for joint meetings; develop objectives for partnerships; sustainability of partnerships.

- Coalition for Juvenile Justice (2000) General Recommendations
    - Effective programs for incarcerated juveniles (more highly structured; focus on skills; focus on behaviors; culturally competent; families involved; community-based rather than institution-based; wrap-around services; youth-focused; strong after-care services).

- Substance Abuse Planning: Strategic Plan for Substance Abuse Prevention, Governor's Initiative (2006)
    - Overall Goals
        - Profile population needs; resources; and readiness to address problems and service gaps (short-term and long objectives identified).
        - Mobilize and build capacity.
        - Develop a comprehensive strategic plan.
        - Monitor; process, evaluate effectiveness; sustain effective programs; improve or replace those that fail.
    - Cross-Cutting Issues:
        - Sustainability: service integration required; support for action plans promoting objectives; develop community-support.
        - Cultural and Linguistic Competence: need for system wide plan; promotion of respect for diversity; services reflect populations served; assess disparities; build coalitions with diverse partners; develop state plan; review processes supporting competencies; evaluate outcomes.
        - Underage Drinking: absorbing more of state budget (review and analysis of problem); include college/age youth; partner with academic institutions.
        - Katrina/Rita Service Interruptions: clarify partnerships; points of contact; capture what is being done; have trained responders; do on-going post-trauma training; document disaster responses; assess human and financial capacity issues; ignore regional boundaries during duress of recovery.

Recommendations on Human Resources

- LaGreca and others (2006) (EBPs in treating childhood trauma)
    - Make sure providers are trained in evidence-based practices (EBPs) and that trauma informed assessments and EBPs are provided.
    - Trauma-focused CBT w/exposure techniques is recommended for not only PTSD but for youth with a wide variety of symptoms that are traumatic stress related (psychoeducation; exposure; cognitive restructuring).

- National Center for Quality and Accountability. (Extracted from Matrix of Evidence-Based Practice Models)
    - There are a wide variety of model programs but a key to quality is maintaining fidelity to the models and replications in different settings

The following table provides a brief descriptive overview of research supported models studied and reported on as those with an evidence-base.

Listing of recommended evidence-based models

Focus	**Setting**	**Problem**	**Program Models Recommended**
Prevention	School	Aggression; disruptive; SEDs; substance abuse; emotions; risk behaviors; suicide	16 programs sited
Prevention/Interventions	School	Violence; aggression	2 programs sited
	Across settings	Mood, conduct, aggression,	21 programs sited
Treatment Models	Clinic	Anxiety; mood; conduct; suicide	23 programs sited
	School	Mood; conduct	7 programs sited
	Across settings	Mood; conduct; aggression; anxiety; suicide; substance abuse	17 programs sited
Crisis Interventions	Across settings	Crises	8 programs

These program models are identified and recommended for implementation for those developing a plan for delivery of evidence-based models. The models are described in this report and fidelity to the models is part of the purpose of identifying the models for local applications.

As a cooperative project, Southern University at New Orleans School of Social Work partnered with LA-Y.E.S. to develop a post-masters certificate program in treating childhood traumatic stress. This program brings together providers from child welfare, juvenile justice, LA-Y.E.S., mental health, and community-based care providers to examine evidence-based and

culturally competent models of care delivery for youth experiencing traumatic stress. The program reviews the evidence-base, and some of this information is briefly summarized below:

- Treatment Guidelines for Trauma/Youth (EBPs) (SUNO/LA-Y.E.S. Certificate Program Review, 2006/07).
  - NIMH Consensus Panel (2002)
    - Caution using "crisis debriefing" model; provide supportive counseling; triage more vulnerable youth; provide community-based services.
  - APA Guidelines for Treating Acute Stress Disorder/Post Traumatic Stress Disorder (PTSD).
    - Community-based; interdisciplinary treatments;
    - Psychopharmacology; trauma focused cognitive behavioral therapy (TFCBT).
  - Nathan & Gorman (Guide to EBPs: PTSD)
    - Psychopharmacology
    - Psychotherapies: TFCBT; (also forms of CBT: exposure; psycho-education; eye movement—EMDR); psychodynamic.
  - Child Trauma Academy
    - 4 most supported models: CBT; psycho-ed; parent-child interpersonal psychotherapy--PCIP; psychopharmacology.
  - National PTSD Center
    - High Evidence: none.
    - Medium Evidence: CBT (TFCBT).
    - Low Evidence: debriefing (cautions); EMDR. Psychopharmacology.
  - American Psychological Association
    - CBT/w/ exposure; pharmacotherapy; EMDR (limited support); brief family therapy.
  - Rand Corporation Studies
    - TFCBT in schools (several models of cognitive behavioral intervention treatment services—CBITS).
  - Maine Department of Mental Health/Department of Social Services studies:
    - Doing uniform trauma informed assessments across all state agencies—link to EBPs for trauma interventions.
    - Most youth in the child welfare, juvenile justice, and mental health system exposed to traumatic stress and interventions should flow from this (using EBPs).
  - Office of Victims of Crime
    - TFCBT; PCIP; CBT.
  - Issues Integral to Child Trauma/TFCBT Model for Practice
    - Community violence (exposure); family driven care; CA/N; sexual abuse; adolescent HIV and risk behaviors/trauma influences; family violence; disaster mental health (Parent Child Interpersonal Psychotherapy—PCIP); Immigrant families/trauma—TFCBT; Cultural and Linguistic Competence; Family Supports (public policy in disasters); Psychopharmacology; Mental health/trauma policy; Fires/death; Cultural and Linguistic Competence with African Americans; Disasters (9-11); vicarious traumatization.

- Other considerations: family focus; ethics; Cultural and Linguistic Competence; spirituality; and substance abuse.

Recommendations for a Comprehensive Array of Services

The Woodrow Wilson School of Public and International Affairs (Bendsen, Blair, Holandez, Lutwick, Parkes, Sagness, and others, January 2007) reviewed Post-Katrina mental health services for children and adults in the Orleans metropolitan area. They examined barriers to care, service provision, funding, and made recommendations to improve the overall system. They addressed five goal areas with specific recommendations with each area.

- Accessibility and affordability;
- Effective and evidence-based treatments;
- Adequate workforce and coordination;
- Sustained financing; and
- Suitable policy environment.

As a result of these goal areas, the group developed several specific recommendations to support these goals. The following table summarizes their recommendations.

Area of Recommendation	**Policy Recommendations**
Workforce Development	o Relocation assistance; training programs; loan repayments; incentives for Spanish speaking providers o Support Academic Partnerships: support helping professional training programs; support psychiatric residency programs; support training in evidence-based interventions
Integration of Mental Health w/Primary Care	Screening at primary care sites; develop shared medical record technology (mental health/primary care); redesign clinic flow to accommodate primary care/mental health care; cross-provider training and coordination activities
Information Systems	Need for improved information sharing (providers; consumers; policy makers) on service design, outcomes, costs; capacity/needs of families different than those of providers for basic information. Focus on three areas: on-line sharing data; print materials; outreach.
Transportation	Need for planning activities as well as service funding

The American Academy of Child and Adolescent Psychiatry (2007) developed recommendations for the establishment of principles and practices to guide the development of community systems of care. Their thirteen recommendations are:

- Assessments and intervention approaches for children and youth are guided by the ecology of their families involving comprehensive information from their formal and informal support networks.
- Providers are partners with families coming from a strengths-based approach.

- Mental health services are integrated with other services provided to families (including juvenile justice, child welfare, and other supportive networks).
- Services are culturally competent respecting diversity and focused on the most vulnerable and at risk children and youth.
- Services are individualized for the child and family and envelope the family in wraparound services.
- Services are based on the evidence-based practices.
- Providers (e.g., psychiatrists) play a variety of roles in teams.
- Psychopharmacology is integrated into care plans where indicated.
- Providers assume advocacy roles on behalf of children and families served.
- Providers and families share accountability for services and accountability is built into service delivery.
- Services are provided in least-restrictive environments, access potential is maximized, and level or intensity of services is based on informed and shared decisions.
- Transitions between systems should be addressed in care delivery.
- Prevention strategies are incorporated into care delivery.

This community system of care approach supports the development of a comprehensive array of services. The Cooperative Agreement between SAMHSA and LA-Y.E.S. outlines the basic structures of this array of services.

SAMHSA (Systems of Care Cooperative Agreement with LA-Y.E.S.—2005-2009)

REQUIRED CMH SERVICES	**OPTIONAL CMH SERVICES**
Diagnosis and evaluation (assessment)	Screening for Eligibility
Care Management	Training (EBPs; ISPs; intensive services; Cultural and Linguistic Competence)
Outpatient (community-based care)	Recreation
Emergency services (24/7)	Individualized Tx
Intensive Home-Based Care (imminent risk)	
Intensive Day Treatment	
Respite Care	
Therapeutic Foster Care	
Therapeutic Group Home Care	
Transitional Services	

The following table is derived from community input from key informants estimating the availability and access to both mandated and optional services essential to the LA-Y.E.S. system of care offered in each of the parishes. This reflects the Post-Katrina fact of service paucity and dire need for children in our service area.

Table reflecting key informant surveys of service infrastructure in the service area

REQUIRED CMH SERVICES	**Orleans**	**Jefferson**	**Plaquemines**	**St. Bernard**	**St. Tammany**
Diagnosis and Evaluation	1	1	1	1	1
Care Management	1	1	1	1	1
Outpatient (community-based)	2	1	1	1	1
Emergency services (24/7)	2	0	0	0	3
Intensive Home-Based Care	2	1	2	1	1
Intensive Day Treatment	1	0	0	0	1
Respite Care	0	0	0	0	1
Therapeutic Foster Care	0	0	0	0	1
Therapeutic Group Home Care	1	1	0	0	2
Transitional Services	0	0	1	1	2
OPTIONAL CMH SERVICES					
Screening for Eligibility	2	1	3	2	1
Training (EBPs; ISPs; intensive services; Cultural and Linguistic Competence)	1	0	1	0	2
Recreation	1	0	0	0	2
Individualized Tx	1	1	0	1	2

0 = services not available; 1 = services exist but very limited/restricted; 2 = exist but limited;
3 = exist widely with no substantive access barriers

Based on the key informant surveys, it is evident that the mental health service infrastructure is in crisis, is extremely limited, and is costing the community by impacting overuse of juvenile justice, child welfare, hospital services is the most restrictive environments rather than in the least restrictive environments provided by community-based care. This crisis costs money by requiring services in more costly institutional structures, and costs increased burden on families and the community. This may well be the highest priority for community redevelopment reflected in this children's mental health plan.

- Recommendations from the Center for Children's Mental Health at Columbia University School of Public Health (2006) based on several community forums in the Gulf Coast affected disaster areas:
    - Technological Recommendations
        - Web-based common site for common access and sharing of trauma informed data; develop web-based disaster response software; shared data bases; updating resource directories (ongoing); on-line discussion groups

(advocates; provides; families); portal to share EBPs (best practices); common site on EBPs for specific problems.
        - Support the 211 call centers.
    - Education Recommendations
        - Need for concerted efforts at training of care providers: parent empowerment; provider training (in what works—evidence-based practices); clinician support (assistance for vicarious trauma); training in psychoparmacotherapies.
        - Develop "empowerment materials" that educate parents on various psychological issues related to their children's mental health; informational tools for providers; resources for pediatricians.
    - Human Resource Recommendations
        - Recruitment and hiring of new professionals (w/orientations; training); secure trained volunteers; support peer to peer and parent/family mentoring programs; tap into student volunteer resources.
    - Financial Recommendations
        - Shared fund development; grant writing; partnerships; maximize donor impact.
    - Recommended manuals on delivering services which are evidence-based and trauma specific (crisis follow ups; depression; anxiety; conduct; and parent empowerment).

- Voices of Youth in New Orleans on Recovery (Center for Empowered Decision Making, 2006)
    - Five Public Policy Themes Emerged from the Youth Forum (13 youth from ages 8-16 from diverse racial/ethnic backgrounds)
        - Safety: need for more police protection; worry about strangers in neighborhoods; concerned about drugs in neighborhoods; worried about future storms.
        - Experienced schools elsewhere: want more and better teachers; schools in disrepair; want a learning environment which supports them and their growth.
        - Places to play/do things; want organized activities; want streets cleaned so they can use them; need playgrounds.
        - Want trash removed; want the city to look clean like places they lived following the storm; feel city attracts others but isn't clean like others.
        - Want the City to be prepared in case of another storm in the future; want plans to think about everyone who is in need; want families to be better informed on what to do.
        - Meetings with service providers supported the themes & priorities expressed by the youth.

Voices of Youth Recommendations

Steering Committee	
	Identify leadership regarding accountability/implementation
	Examine history of services—leverage successes
	Focus on synergies: collaborate with people working together
	Reconvene relevant partners in children's mental health of those doing wraparound
	Develop service resource guides and online resources
	Develop a system to share information with the public
Steering/Subcommittee Leaders	
	Employ a consensus model balanced with accountability
	Prioritize children's needs and capacities
	Identify existing resources/establish new focuses
	Strengthen children's coalitions/collaborative
	Create of comprehensive children's plan which includes physical, mental, social, and spiritual health
	Establish a vision statement
	Continue to develop collaborative partnerships
	Reconvene strategic dialogue and action agenda setting
	Provide organized opportunities to promote networking
	Continually examine community needs directly coming from the communities
	Better coordinate the funding streams coming into community
	Use PSA's to inform communities
Play/Things to Do	
	Explore city progress on inclusive recreational and extracurricular activities for youth
	Show children's video to City Council
Improved Schools	
	Work with neighborhood planning groups on schools
	Support better teacher training
Plan/Prepare/Protect	
	Track housing initiatives and share information
	Continue ongoing examination of evacuation plans
Family Services	
	Establish comprehensive health/mental health services in schools
	Revitalize strategic planning and coordinate body for social services (including wraparound)
	Work directly with youth via schools
	Work with children not living with parents
	Increase cultural and linguistic competency (training)
	Help grandparents raising grandchildren
	Establish more parenting classes/better approaches
Safer, Cleaner City	
	Identify youth leaders to work on these issues

- Center for Children's Mental Health's Legislative Recommendations (2006)
    - Expand Medicaid coverage.
    - Cautions: cost sharing; increased premiums; benefit levels (results: avoid utilization; difficulty w/prescriptions; maintaining coverage).
    - Watch prevention packages from the EPSDT services (comprehensive developmental histories; comprehensive physical exams; immunizations; lab tests; screenings (lead; vision; hearing; dental); and health education.
    - Enabling services vital: transportation.
    - Medicaid waivers are jeopardized by funding streams/reimbursement requirements. Eligibility requirements for evacuees need reconsiderations. Studies by the NCTSN estimates 100,000 children will experience PTSD—while no system is in place to provide coverage, service, training, and infrastructure.
    - Existing funding structures (CDC; SAMHSA; Preventive Health and Human Services Bock Grant) needs to prioritize impacted area.
    - NB: 10 point emergency plan:
        - Recognize the urgency (hold hearings).
        - Medicaid waiver process does not adequately provide flexibility state(s) need.
        - Address the designated Health Profession Shortage Area.
        - Deploy the USPHS (under the direction of the Surgeon General) to the area until shortages addressed (817 physicians needed) (2,000/1 ration needed).
        - Expand capacity of the community health care system.
        - Support advances in health technology (uniform records; statewide registries; tele-med).
        - Enhance transportation capacity of provider base (to area already in crisis for lack of transpiration to the medically needy.
        - Avoid restrictions on post-disaster mental health services; expand capacity for comprehensive mental health services; expand Medicaid coverage of mental health.
        - Expand school-based mental health coverage (already established and expanded need is extensive); have centers become referral sites.
        - A massive over-sight system control is needed: a Marshall Plan for Mental Health in the area.

- Huffman and others (2004): Use of Outcome Data in Children's Mental Health
    - For improving utilization of effective interventions for children and youth in mental health services, some findings may influence approaches to improvements: providers generally view outcome data collection positively (psychiatrists somewhat less than other provides); those with more positive views expressed less burden by implementing them; those with more positive views were supported in these views by the organizational climate.

- As noted above, the Center for Mental Health Services evaluations (SAMHSA, 2007) documents wide success of providing comprehensive services to families with vulnerable

and at risk youth with mental health challenges. In summarizing this research, the National Center for Children and Poverty (2006) recommend the following based on this broad national evaluation data:

- Improve mental health access consultation with a specific focus on young children.
- Coordinate services and hold youth serving agencies accountable.
- Provide mental health services and supports that meet developmental needs of children.
- Apply consistent use of effective treatments and supports.
- Engage families and youth in their own treatment planning and implementation.
- Provide culturally and linguistically competent services.
- Implant concrete strategies to prevent and identify mental health problems and intervene early.

PART III

PRIORITIES AND CONSENSUS STATEMENTS

THE LA-Y.E.S. CHILDREN'S MENTAL HEALTH PLAN

This plan is based on the data informing our system of care development, the input from families and youth in the process, the shared ideas from providers and the consortia stakeholders, and from recommendations from the LA-Y.E.S. Administrative Services Organization. After receiving considerable input into the planning process and in collaboration with families, youth and other key stakeholders, LA-Y.E.S. prioritizes and recommends the following key priorities for 2007/2008.

PRINICPLE RECOMMENDATION

- Develop a "Marshall Plan" to address the wide-ranging children's needs in disaster affected areas. This should address access to care (affordability; trained providers; expand capacity; crisis care; effective services; transportation). Access needs to be addressed for mild/moderate (e.g., depression; anxiety disorders; PTSD) to severe (major depression; severe anxiety; severe PTSD; schizophrenia; and bipolar). The service delivery system is grossly deficient to address the need.

The following table is repeated to demonstrate the systems wide need.

REQUIRED CMH SERVICES	**Orleans**	**Jefferson**	**Plaquemines**	**St. Bernard**	**St. Tammany**
Diagnosis and Evaluation	1	1	1	1	1
Care Management	1	1	1	1	1
Outpatient (community-based)	2	1	1	1	1
Emergency services (24/7)	2	0	0	0	3
Intensive Home-Based Care	2	1	2	1	1
Intensive Day Treatment	1	0	0	0	1
Respite Care	0	0	0	0	1
Therapeutic Foster Care	0	0	0	0	1
Therapeutic Group Home Care	1	1	0	0	2
Transitional Services	0	0	1	1	2
OPTIONAL CMH SERVICES					
Screening for Eligibility	2	1	3	2	1
Training (EBPs; ISPs; intensive services; Cultural and Linguistic Competence)	1	0	1	0	2
Recreation	1	0	0	0	2
Individualized Tx	1	1	0	1	2

0 = services not available; 1 = services exist but very limited/restricted; 2 = exist but limited;
3 = exist widely with no substantive access barriers

RECOMMENDATIONS ON VULNERABLE YOUTH & THE SAFETY NET

- Develop strategies for systematic engagement of families and youth in service planning, implementation, and evaluation.
- Develop strategies and resources to expand the basic mental health infrastructure including SAMHSA "required services" for successful systems of care within the service area.
- Develop strategies and resources to expand mental health support services such as SAMHSA "optional services" for successful systems of care to the most at risk and vulnerable youth in the service area.
- Collaborate with Medicaid and LaCHIP to enroll all eligible children in the service area.
- Collaborate with Medicaid for a waiver and with other key childhood stakeholders to enroll all children with serious emotional and behavioral disorders.
- Expand access to and resources for integration of family supports into service plans, such as transportation and child care.
- Provide supports to help parents because how well they cope dictate how well their children cope.
- Expand the focus on cultural and linguistic competence standards promoted through training, establishment of benchmarks, ongoing monitoring, and regular outcome reporting.
- Focus services on youth with serious emotional and behavioral problems who have the greatest vulnerabilities and traumatic stress.
- Incorporate trauma informed assessments across service provider agencies for youth services in the area.
- Document service outcomes for all youth and their families engaged in the service delivery network.
- Provide adequate evidence-based mental health services in schools.
- Develop strategies to train teachers and counselors to work with youth with mental health problems.
- Provide training to stakeholders in the system of care philosophy and practices.
- Provide wraparound services to families to help navigate systems of care.

RECOMMENDATIONS ON SYSTEM OF CARE HUMAN RESOURCE ISSUES

- Engage families, youth, and key stakeholders (child welfare; juvenile justice; mental health; education) in collaborative efforts with providers at systems reform.
- Focus on high quality training for service providers in key service delivery areas: evidence-based practice; best practices; cultural and linguistic competency; family/youth engagement; and vicarious traumatization.
- Collaborate to develop trauma informed care across youth services (juvenile justice; child welfare; mental health; and counseling services.
- Engage in stigma reduction, especially among diverse at risk populations.

- Train providers and develop resources to support the evidence-based approach of "wraparound" comprehensive services across systems in the service delivery area.
- Develop data bases for sharing information integrating services and supporting family involvement in care planning, implementation, and evaluation.
- Establish collaborative agreements between community-based recreation and growth development programs for the youth served in the area.
- Develop resources and provide training and support for increasing the capacity and effectiveness of professional mental health service providers.
- Develop stakeholder input in the evaluation and cost-effectiveness assessments of service delivery across systems of care.
- Collaborate with academic and other training programs to support the systems goals and training activities required to inform systems improvement.
- Establish a consensus panel (e.g., the Hawaii "blue book" model) comprised of families, youth, providers, and academics to plan for the selection, development and monitoring of the delivery of evidence-based practices.
- Provide incentives or activities to increase the array of services of community providers.
- Support integration of mental health services with primary care (e.g., screenings; shared medical records; redesign of clinic flows).
- Develop sharing data mechanisms (focus on consumers; providers): services; operations; linguistic diversity; capacity; costs; outcomes.
- Coordinate care using multiple approaches (e.g., on line; printed materials; outreach).

RECOMMENDATIONS FOR LEGISLATIVE SUPPORT FOR SYSTEM CHANGE

- Expand Medicaid coverage to broaden service penetration for youth with serious emotional and behavioral disorders (including wraparound and other evidence-based interventions).
- Provide for trauma informed review for all served by public agencies (child welfare; juvenile justice; education; mental health) and implement evidence-based interventions.
- Expand enabling resources to engage families in service delivery (transportation; child care).
- Expand Medicaid waivers to include care management and wraparound services for children and youth with emotional or behavioral problems and also for those exposed to traumatic stress.
- Address service provider shortage of trained and qualified mental health and care management providers in the disaster exposed areas (e.g., relocation assistance; supported training; loan repayments; incentives for bilingual staff).
- Expand and supplement service capacity for the numbers of children served in community based programs through public and private providers.
- Support building capacity for communication and data transfer technology in communities serving at risk and vulnerable youth.
- Expand accountability for program collaboration and service integration between agencies in service delivery areas.
- Expand and develop training and supports for children's service providers.

- Secure funds which allow access to care through provision of support services such as transportation (planning and services), child care, and recreational activities.
- Develop Program/Provider partnerships with Academic Programs (invest in training programs for professional training—e.g., social work, psychology, psychiatry); develop training partnerships.
- Provide crisis services (acute care beds; crisis teams—e.g., Memphis Crisis Intervention Teams model; CART) and community-based services to prevent more restrictive and costly residential care.

We are not talking about mental illness, but we're talking about the distress children experience after disasters that are seen most as the normal responses to a traumatic event. These behavioral and emotional responses that can be seen manifest themselves for years following the tragedy if attention and support are not provided **(Naturle, May 12, 2007).**

REFERENCES

Abramson, D. & Garfield, R. (2006). *On the edge: Children and families displaced by Hurricane Katrina and Rita face a looming medical and mental health crisis.* New York: Mailman School of Public Health, Columbia University.

Adolescent School Health Initiative (Jefferson Parish Public School System). (2005 -2006. Annual Report.

Agenda for Children. (2007). Status of child care facilities in Orleans Parish. Available at the Community Data Center on February 22, 2007 at www.gnocdc.org.

American Academy of Child and Adolescent Psychiatry. (2007). Practice parameters on child and adolescent mental health care in community systems of care. *Journal of the Academy of Child and Adolescent Psychiatry, 46*(2), 284-299.

American Immigration Law Foundation. *Immigration policy brief: The growth and reach of immigration.* Retrieved from www.ailf.org/ipc/policybrief/policybrief_2006_81606.shtml on April 2, 2007.

Bendsen, C., Blair, R., Holandez, R., Lutwick, A., Parkes, F., Sagness, J. et al. (2007). *Coping with Katrina: Mental health services in New Orleans: Challenges and opportunities.* New Jersey: Princeton University, Woodrow Wilson School of Public and International Affairs.

Campaign for Children's Health Care. (2006). *Louisiana's uninsured children.* Available on March 2007 at www.childrenshealthcampaign.org.

Carassok, A., Steuerle, C. E., & Reynolds, G. (2007). *Kids' share 2007: How children Fare in the federal budget.* Washington DC: Urban Institute Report.

Center for Empowered Decision Making. (September and December, 2006). *Prepare for the children: A critical phase of recovery.* New Orleans, LA: Authors (report on community meetings).

Center for Mental Health Quality and Accountability. (2005). Synthesis *of reviews of children's evidence-based practices.* Washington DC: authors.

Center for the Advancement of Children's Mental Health. (2006, June). Report of the meeting: *Operation assist: Children's mental health*. Minutes provided by the Center, March 2007.

Children's Health Care Campaign. (2006). Louisiana's uninsured children. Found February 26, 2007, at www.childrenshealthcampaign.org.

Coalition for Juvenile Justice. (2000). Annual report. Washington DC: authors.

Community Data Center. Status of Public Schools in Orleans Parish. Available on February 22, 2007 at www.gnocdc.org .

Community Data Center. Katrina Index. Available on March 23, 2007 at www.gnocdc.org.

Copeland, W. E. et al. (2007). Traumatic events and post traumatic stress in childhood. *Archives of General Psychiatry, 64*, 577-584.

Davis, M., Geller, J. L., & Hunt, B. (2006). The availability and accessibility of transition-to-adulthood services for youth with serious mental health conditions. *Psychiatric Services, 57*, 1594-99.

Fussell, E. (2006). *Latino immigrants in post-Katrina New Orleans.* New Orleans, LA: Tulane University Sociology Department.

Golden, O. (2006). *Young children and Katrina: A proposal to heal the damage and*

create opportunity in New Orleans. Washington DC: Urban Institute.
Government Accounting Office (GAO). 2006, March 28. *Status of the health care system in New Orleans.* Washington DC: Authors.
Greater New Orleans Community Data Center. Public school enrollment; Open hospitals. Available at www.gnocdc.org on March 19, 2007.
Gurwitch, R. H. & Silovsky, J. F. (2005). *Reactions and guidelines for children following Hurricane Katrina.* Oklahoma City, OK: University of Oklahoma Health Sciences Center. (Available for distribution by contacting LA-YES).
Housing and Urban Development (HUD). (2007). National *report on homelessness.* Washington DC: HUD.
Huffman, L. C., Martin, J., Botcheva, L., Williams, S. E., & Dyer-Friedman, J. (2004). Practitioners' attitudes toward the use of treatment progress and outcome data in child mental health. *Evaluation & the Health Professions, 27*, 165-188.
James, C., Thomas, M., & Lillie-Brown, M. (2007). *Race, ethnicity, and health care.* Available February 26, 2007 at www.dff.org.
Kaiser Family Foundation. (February 26, 2007). Women's health policy facts.
Kaiser Family Foundation. *State health facts: Fact Sheets.* Available on March 23, 2007 at www.statehealthfacts.org.
Kaiser Family Foundation. (May 12, 2007). *Giving voice to the people of New Orleans: The Kaiser Post-Katrina baseline survey.* Downloaded on May 12, 2007 at www.kff.org.
Knitzer, J. & Lefkowitz, J. (January 2006). *Helping the most vulnerable infants, toddlers, and their families.* New York, NY: National Center for Children in Poverty.
LeGreca, A. M., Silverman, W. K., Vernberg, E. M., & Roberts, M. C. (2002). *Helping children cope with disasters and terrorism.* Washington DC: American Psychological Association Press.
Lister, S. (2005). Hurricane Katrina: The public health and medical consequences. CRS Report to Congress RL33096. Washington DC: Congressional Research Services, September 21.
Louisiana Department of Health and Hospitals. 2004-2005 Louisiana Medicaid annual report. Available on February 24, 2007 at www.dhh.la.gov.
Louisiana Office of Mental Health. (2007). Louisiana *FY 2007 block grant plan.* Baton Rouge, LA: Office of Mental Health.
Louisiana Recovery Authority. (2007). *A report on the impact of Hurricanes Katrina and Rita on Louisiana businesses.* Baton Rouge, LA: LSU College of Business.
Madrid, P. A., Grant, R., Reilly, M. J., & Relener, N. B. (2006). Challenges in meeting immediate emotional needs: Short term impact of a major disaster on children's mental health. *Pediatrics, 117*(5), S448-453.
Maggi, L. & Moran, K. (April 23, 2007). Mental patients have no where to go. Times Picayune, pp. A1, A4.
Mental Health America. (February 5, 2007). News report. Available on website on March 8, 2007 at www.mentalhealthamerica.net.
National Center for Children in Poverty. (2005). *Child poverty in states hit by Hurricane Katrina: Fact Sheet.* New York: Mailman School of Public Health, Columbia University.
National Center for Children in Poverty. (2006). *Children's mental health: Facts for*

policymakers. New York: Mailman School of Public Health, Columbia University.
National Center for Disaster Preparedness. (2007). *The recovery divide: Poverty and the widening gap among Mississippi children and families affected by Hurricane Katrina.* New York: Mailman School of Public Health, Columbia University.
National Child Traumatic Stress Network. (2004). *Children and trauma in America: A progress report.* Los Angeles, CA: UCLA Neuropsychiatric Institute.
National Council for Community Behavioral Healthcare. *Lost in transition: People with mental illness slipping through fault-lines along continuum of care.* Retrieved from www.ncchb.org on April 2, 2007.
National Council on Crime and Delinquency. (2006). And *justice for some: Differential treatment of youth of color in the juvenile justice system.* Available on February 22, 2007 at http://www.nccdcrc.org.
National Institute for Health Care Management. (2007, February). *Reducing health disparities among children: Strategies and programs for health plans.* Available at www.nihcm.org March 30, 2007.
Naturale, A. (2007, May 12, 2007). Quoted from April Naturale's presentation at the Post -Master's Certificate Program in Treating Child Traumatic Stress. New Orleans, LA: Southern University at New Orleans School of Social Work.
New Freedom Commission. (2003). Achieving *the promise: Transforming mental health care in America.* Rockville, MD: Department of Health and Human Services.
Office of Community Services. *2005 Annual progress and service report.* Available at www.dss.la.gov on April 25, 2007.
Office of Youth Development. *Demographic profiles of youth in the juvenile detention populations in Louisiana*. Available at www.oyd.gov on April 25, 2007.
Pires, S. A. (2002). *Building systems of care.* Washington DC: National Technical Center for Children's Mental Health.
Ray, N. (2007). *An epidemic of homelessness: Lesbian, gay, and transgendered youth.* Washington DC: National Lesbian and Gay Task Force Policy Institute and the National Coalition for the Homeless.
SAMHSA (Substance Abuse Mental Health Services Administration. Children's mental health facts. Available at www.mentalhealth.samhsa.gov on March 25, 2007.
SAMHSA (Substance Abuse Mental Health Services Administration. Comprehensive community mental health services for children and their families. Available at www.sysemsofcare.samhsa.gov on May 9, 2007.
SAMHSA. (2005). Transforming *mental health care in America.* Rockville, MD: Department of Health and Human Services.
Shores, E. F., Grace, C., Bararo, E., Barbaro, M. & Moore, J. (2006). *Orleans Parish, LA: Child care assessment.* Mississippi State University, MS.
Silverman, W. K. & LeGreca, A. M. (2002). Children experiencing disasters. In A. M. LeGreca, W. K. Silverman, E. M. Vernberd & M. C. Roberts, Editors Helping *children cope with disasters and terrorism* (pp. 11-34). Washington DC: American Psychological Association Press.
State of Louisiana. (2006, July 13). *Strategic plan for substance abuse prevention: 2006-2010.* Baton Rouge, LA: The Governor's Initiative to Build a Healthy Louisiana.
Stroul, B. & Friedman, R. (1986). *A system of care for children and youth with severe*

emotional disturbances (revised). Washington DC: Georgetown University Child Development Center.
Times Picayune. (April 30, 2007; A1, A5). Special education not in place.
Zedlewski, S. R. (2006). *After Katrina: Rebuilding opportunity and equity into the "new" New Orleans.* Washington DC: Urban Institute.
Zuckerman, S. & Coughlin, T. (2006, February). Initial health policy responses to Hurricane Katrina and possible next steps. *After Katrina: Rebuilding opportunities and equity In the 'New' New Orleans.* Available for download on January 23, 2007 from http://www.urban.org.

Contact Information on this Report

Ronald J. Mancoske
Professor of Social Work/Evaluation Consultant
SUNO/LA-Y.E.S.
6801 Press Drive
New Orleans, LA 70126
504-286-5376 or 504- 896-2636 (or at email ronm1450@msn.com)